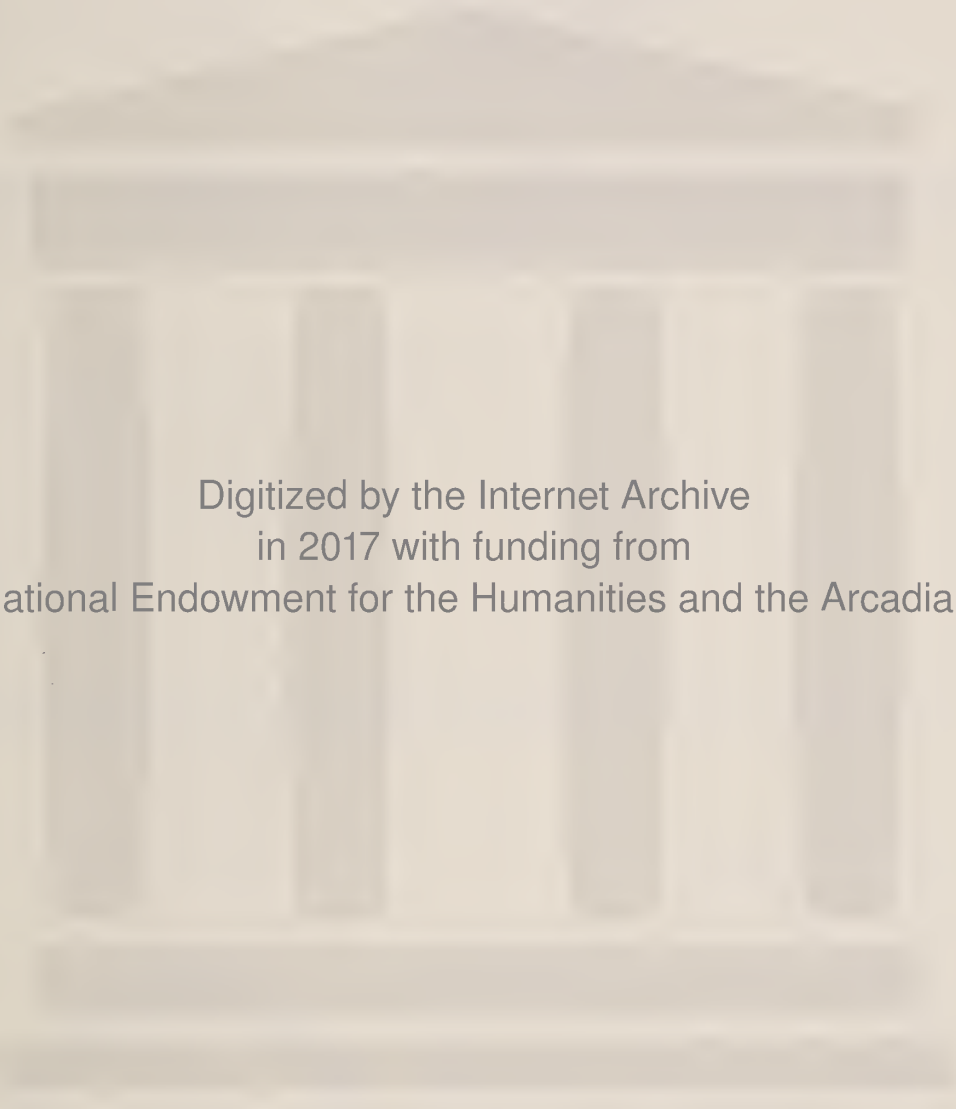
PER

The New York
Academy of Medicine



The Henry W. and
Albert A. Berg
Fund

Established 1950



Digitized by the Internet Archive
in 2017 with funding from
The National Endowment for the Humanities and the Arcadia Fund

https://archive.org/details/rhodeislandmedic45unse

JANUARY, 1962

RHODE ISLAND

Medical Journal

Medical Economics Issue

* * * *

Sesquicentennial Year, 1962

Volume XLV, No. 1

Table of Contents, page 3

THE N Y ACADEMY OF MEDICINE
FEB 13 1962
LIBRARY

a look at the literature



"an excellent drug

Based both on laboratory studies and clinical impressions, it [Cordran] appears to be an excellent drug for the relief of cutaneous inflammation, possibly more effective than any steroid we have hitherto used."

—Rostenberg, A., Jr.: Clinical Evaluation of Flurandrenolone, a New Steroid, in Dermatological Practice, J. New Drugs, 1:118, 1961.

Description: Cordran cream and ointment contain 0.5 mg. Cordran per Gm. Cordran™-N cream and ointment contain 0.5 mg. Cordran and 5 mg. neomycin sulfate per Gm.

Lilly

Cordran™-N (flurandrenolone with neomycin sulfate, Lilly)

Product brochure available; write Eli Lilly and Company, Indianapolis 6, Indiana.

This is a reminder advertisement. For adequate information for use, please consult manufacturer's literature.

240209

when urinary tract infections present a therapeutic challenge...

CHLOROMYCETIN®

(chloramphenicol, Parke-Davis)

Often recurrent...often resistant to treatment, urinary tract infections are among the most frequent and troublesome types of infections seen in clinical practice.[1,2] In such infections, successful therapy is usually dependent on identification and susceptibility testing of invading organisms, administration of appropriate antibacterial agents, and correction of obstruction or other underlying pathology.

Of these agents, one author reports: "Chloramphenicol still has the widest and most effective activity range against infections of the urinary tract. It is particularly useful against the coliform group, certain Proteus species, the micrococci and the enterococci."[1] CHLOROMYCETIN is of particular value in the management of urinary tract infections caused by *Escherichia coli* and *Aerobacter aerogenes*.[3] In addition to these clinical findings, the wide antibacterial range of CHLOROMYCETIN continues to be confirmed by recent *in vitro* studies.[4-6]

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100. See package insert for details of administration and dosage.

Warning: Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, granulocytopenia) are known to occur after the administration of chloramphenicol. Blood dyscrasias have occurred after both short-term and prolonged therapy with this drug. Bearing in mind the possibility that such reactions may occur, chloramphenicol should be used only for serious infections caused by organisms which are susceptible to its antibacterial effects. Chloramphenicol should not be used when other less potentially dangerous agents will be effective, or in the treatment of trivial infections, such as colds, influenza, or viral infections of the throat, or as a prophylactic agent. *Precautions:* It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

References: (1) Malone, F. J., Jr.: *Mil. Med.* **125**:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* **34**:187, 1959. (3) Ullman, A.: *Delaware M. J.* **32**:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* **108**:48, 1961. (5) Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: *Antibiotics & Chemother.* **10**: 694, 1960. (6) Lind, H. E.: *Am. J. Proctol.* **11**:392, 1960.

68961

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit 32, Michigan

JUN 3 1 1964

NEW YORK ACADEMY OF MEDICINE

353410



Reading time: 1 minute

BRIEFS

FROM THE PHYSICIANS SERVICE PLAN OF THE RHODE ISLAND MEDICAL SOCIETY

January, 1962

A Doctor Asked...

"How Can I Determine The Eligibility of a Subscriber for Service Benefits?"

There are probably several ways to determine a subscriber's eligibility. The one that has proved most acceptable to the subscriber and the doctor is to discuss Physicians Service Benefits with the subscriber *before* the services are performed.

This approach has these advantages:

1. It is in accord with the AMA and Rhode Island Medical Society policy that a doctor discuss his fee with the patient.
2. The subscriber's eligibility for service benefits depends basically upon whether the subscriber is *over* or *under* the income limit. (See Part II of the Physicians Service contract for details.)
3. It gives the doctor an opportunity to explain to the subscriber any charges he will be making for services which are not covered under the terms of the subscriber's contract.
4. It gives the subscriber a sense of security to know exactly what his financial obligation will be.
5. It proves to the subscriber that the Participating Doctor actively supports Physicians Service as a *voluntary* prepayment health care program.

And, Physicians Service personnel welcome questions from doctors and secretaries about subscriber service benefit conditions.

Over 300,000 cases a year...

Over *300,000* physicians' claims were processed by your Physicians Service Plan alone during 1961. This means that 1,200 claims are handled each working day . . . 150 claims every hour . . . 2½ claims each working minute.

This fact alone is significant testimony to the value of Physicians Service to the Rhode Island community.

The RHODE ISLAND MEDICAL JOURNAL

Editorial and Business Office: 106 Francis Street, Providence, R. I.

Editor-in-Chief: SEEBERT J. GOLDOWSKY, M.D.

Managing Editor: JOHN E. FARRELL, SC.D.

Senior Editors

ALEX M. BURGESS, SR., M.D. HENRI E. GAUTHIER, M.D.

Advisory Board

(in addition to editors listed above)

JOHN A. DILLON, M.D. JOHN F. W. GILMAN, M.D. ROBERT V. LEWIS, M.D.
PETER L. MATHIEU, M.D. JOSÉ M. RAMOS, M.D. ROBERT W. RIEMER, M.D.
JACK SAVRAN, M.D. LESTER L. VARGAS, M.D.

Owned and Published Monthly by
THE RHODE ISLAND MEDICAL SOCIETY
Second-class postage paid at Providence, Rhode Island
Copyright, 1962, the Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island
Single copies, 25 cents . . . Subscription, $2.00 per year.

Volume XLV, No. 1 January, 1962

TABLE OF CONTENTS

PAGE

SOME PRACTICAL CHALLENGES TO MODERN MEDICINE, *Justice Joseph R. Weisberger* 21

THE BLUE SHIELD CHALLENGE, *Francis R. Smith* 25

WHAT IT'S LIKE TO PRACTICE UNDER SOCIALIZED MEDICINE, *Edwin L. Dawe,* M.D. 30

USE, BUT DO NOT ABUSE, *Pascal F. Lucchesi,* M.D. 32

REFLECTIONS ON THE KING-ANDERSON BILL (H.R. 4222), *Rev. Stanley Parry,* C.S.C., PH.D. 35

PROFESSIONAL SERVICES INDEX STUDY, *William H. Horton,* M.D. 42

EDITORIALS

"The Flabby American" 39
Medical Teaching and the Movies 39
Aviation Medicine 40

DEPARTMENTS

A.M.A. Clinical Session, Report of Rhode Island Delegates 48
Necrology, 1961, The Rhode Island Medical Society 52
District Medical Society Meetings 56
Through the Microscope 59
Book Reviews 63

MISCELLANEOUS

Index of Advertisers 64



Emotional control regained . . . a family restored . . . thanks to a physician and 'Thorazine'

During the past seven years, 'Thorazine' has become the treatment of choice for moderate to severe mental and emotional disturbances, because it is:

- specific enough to relieve underlying fear and apprehension
- profound enough to control hyperactivity and excitement
- flexible enough so that in severe cases dosage may be raised to two or three times the recommended starting level

Experience in over 14,000,000 Americans confirms the reassuring fact that, in most patients, the potential benefits of 'Thorazine' far outweigh its possible undesirable effects.

Of special value in mental and emotional disturbances: Tablets for initial therapy; Injection (Ampuls and Vials) for prompt control; Spansule® sustained release capsules for all-day or all-night therapy with a single oral dose.

Thorazine® brand of chlorpromazine
a fundamental drug in both
office and hospital practice
Smith Kline & French Laboratories

SK&F

posed by professional models

'THORAZINE' PRESCRIBING INFORMATION

Because of its pronounced calming effect, 'Thorazine' is an outstanding agent for patients with mental and emotional disturbances, particularly those with symptoms of agitation and hyperactivity. In severe cases, initial use of intramuscular administration may be desirable to control symptoms promptly.

Before prescribing 'Thorazine' for other indications than those given below, the physician should be familiar with the dosage, side effects, cautions and contraindications for such uses. This information is available in the *Thorazine® Reference Manual* and *Physicians' Desk Reference*, and from your SK&F representative or your pharmacist.

ADMINISTRATION AND DOSAGE

Dosage should always be adjusted to the response of the individual and according to the severity of the condition. It is important to increase dosage until symptoms are controlled or side effects become troublesome. In emaciated or senile patients, dosage increases should be made more gradually than in other patients.

ADULT DOSAGE

Mental and Emotional Disturbances (e.g., agitation, excitement, or anxiety)—*Starting oral dosage* is 10 mg. t.i.d. or q.i.d., or 25 mg. b.i.d. or t.i.d. After a day or two, dosage may be increased by increments of 20 mg. to 50 mg. daily, at semiweekly intervals, until maximum clinical response is achieved. Continue dosage at this level for at least two weeks; then it can usually be reduced to a maintenance level. A daily dosage of 200 mg. is "average," but some patients may require substantially higher dosages. Discharged mental patients, for example, may require daily dosages as high as 800 mg. *Starting intramuscular dose* is 25 mg. (1 cc.). If necessary, and if no hypotension occurs, repeat the initial dose in one hour. Subsequent dosages should be oral, starting at 25 mg. to 50 mg. t.i.d.

Alcoholism—Severely agitated patients: *Starting intramuscular dose* is 25 mg. to 50 mg. (1-2 cc.). Repeat initial dose if necessary and if no hypotension occurs. Start subsequent oral dosages at 25 mg. to 50 mg t.i.d. **Agitated but manageable patients:** *Starting oral dose* is 50 mg., followed by 25 mg. to 50 mg. t.i.d. For ambulatory patients with withdrawal symptoms or sober chronic alcoholics, *starting oral dosage* is 10 mg. t.i.d. or q.i.d., or 25 mg. b.i.d. or t.i.d. Patients in a stuporous condition should be allowed to sleep off some of the effects of the alcohol before 'Thorazine' is administered.

CHILDREN'S DOSAGE

For Behavior Disorders—*Oral dosage* is on the basis of ¼ mg./lb. of body weight q4-6h, until symptoms are controlled (i.e., for 40 lb. child—10 mg. q4-6h). *Rectal dosage* is on the basis of ½ mg./lb. of body weight q6-8h, p.r.n. (i.e., for 20-30 lb. child—half of a 25 mg. suppository q6-8h). *Intramuscular dosage* is on the basis of ¼ mg./lb. of body weight q6-8h, p.r.n. In children up to 5 years (or 50 lbs.)—not over 40 mg./day; in children 5-12 years (or 50-100 lbs.)—not over 75 mg./day except in extreme unmanageable cases. In severe cases, higher dosages than those recommended above may be necessary. In such cases, 50-100 mg. daily has been used and, in older children, as much as 200 mg. daily or more may be required.

IMPORTANT NOTES ON INJECTION

Except for acute ambulatory cases, parenteral administration should generally be reserved for bedfast patients. Parenteral administration should always be made with the patient lying down and remaining so for at least ½ hour afterward because of possible hypotensive effects. The injection should be given *slowly, deep* into the upper outer quadrant of the buttock. If irritation and pain at the site of injection are problems, dilution of 'Thorazine' Injection with physiologic saline solution or 2% procaine solution may be helpful. Subcutaneous administration is not advisable, and care should be taken to avoid injecting undiluted 'Thorazine' Injection into a vein. Intravenous administration is recommended only for severe hiccups and surgery.

'Thorazine' Injection should not be mixed with other agents in the syringe. Because contact dermatitis has been reported with 'Thorazine', nurses or others giving frequent injections should avoid getting the solution on hands or clothing. 'Thorazine' Injection should be protected from light, since exposure may cause discoloration. Slight yellowish discoloration will not alter potency or efficacy. If markedly discolored, the solution should be discarded.

SIDE EFFECTS

The drowsiness caused by 'Thorazine' is usually mild to moderate and disappears after the first or second week of therapy. If, however, drowsiness is troublesome, it can usually be controlled by lowering the dosage or by administering small amounts of dextro amphetamine.

Other side effects reported occasionally are dryness of the mouth, nasal congestion, some constipation, miosis in a few patients and, very rarely, mydriasis.

Mild fever (99°F.) may occur occasionally during the first days of therapy with large intramuscular doses.

Some patients have an increased appetite and gain weight, but usually reach a plateau beyond which they do not gain.

CAUTIONS

Jaundice: The over-all incidence of jaundice due to 'Thorazine' has been low—regardless of indication, dosage, or mode of administration. It appears to be related to duration of therapy. Few cases have occurred in less than one week or after six weeks. The jaundice that has occurred mimics the obstructive type, is without parenchymal damage, and is usually promptly reversible upon the withdrawal of 'Thorazine'. Although the mechanism is not clearly understood, most investigators conclude that it is a sensitivity reaction in susceptible individuals.

There is no conclusive evidence to indicate that pre-existing liver disease makes the patient more susceptible to jaundice. (Patients with known alcoholic cirrhosis have been treated with 'Thorazine' without further alteration of liver function.) Nevertheless, 'Thorazine' should be used with due consideration in a patient with liver disease.

If a patient on 'Thorazine' suddenly develops fever with grippe-like symptoms, his serum should be tested for increased bilirubin or his urine for the presence of bile. If any of these tests are positive, 'Thorazine' should be discontinued.

Because detailed liver function tests of 'Thorazine'-induced jaundice give a picture which mimics extrahepatic obstruction, exploratory laparotomy should be withheld until sufficient studies confirm extrahepatic obstruction.

Agranulocytosis: Agranulocytosis, although rare, has been reported. Patients should be observed regularly and asked to report at once the sudden appearance of sore throat or other signs of infection. If white blood counts and differential smears give an indication of cellular depression, the drug should be discontinued, and antibiotic and other suitable therapy should be instituted.

Because most reported cases have occurred between the fourth and the tenth weeks of treatment, patients on prolonged therapy should be observed particularly during that period.

A moderate suppression of total white blood cells, sometimes observed in patients on 'Thorazine' therapy, is not an indication for discontinuing 'Thorazine' unless accompanied by other symptoms.

Potentiation: 'Thorazine' prolongs and intensifies the action of many central nervous system depressants such as anesthetics, barbiturates and narcotics. Consequently, it is advisable to stop administration of such depressants before initiating 'Thorazine' therapy. Later the depressant agents may be reinstated, starting with low doses, and increasing according to response. Approximately ¼ to ½ the usual dosage of such agents is required when they are given in combination with 'Thorazine'. (However, 'Thorazine' does not potentiate the anticonvulsant action of barbiturates. In patients who are receiving anticonvulsants, the dosage of these agents—including barbiturates—should not be reduced if 'Thorazine' is started. Rather, 'Thorazine' should be started at a very low dosage and increased, if necessary.)

Hypotensive Effect: Postural hypotension and simple tachycardia may be noted in some patients. In these patients, momentary fainting and some dizziness are characteristic and usually occur shortly after the first parenteral dose, occasionally after a subsequent parenteral dose—very rarely after the first oral dose. In most cases, prompt recovery is spontaneous and all symptoms disappear within ½ to 2 hours with no subsequent ill effects. Occasionally, however, this hypotensive effect may be more severe and prolonged, producing a shock-like condition.

In consideration of possible hypotensive effects, the patient should be kept under observation (preferably lying down) for some time after the initial parenteral dose. If, on rare occasions, hypotension does occur, it can ordinarily be controlled by placing the patient in a recumbent position with head lowered and legs raised. If a vasoconstrictor is required, 'Levophed' and 'Neo-Synephrine'* are the most suitable. Other pressor agents, including epinephrine, are not recommended because phenothiazine derivatives may reverse the usual elevating action of these agents and cause a further lowering of blood pressure.

Antiemetic Effect: The antiemetic effect of 'Thorazine' may mask signs of overdosage of toxic drugs and may obscure diagnosis of conditions such as intestinal obstruction and brain tumor.

Dermatological Reactions: Dermatological reactions have been reported. Most have been of a mild urticarial type, suggesting allergic origin. Some appear to be due to photosensitivity, and patients on 'Thorazine' should avoid undue exposure to the summer sun.

Neuromuscular (Extrapyramidal) Reactions: With very high doses of 'Thorazine', as frequently used in psychiatric cases over long periods, a few patients have exhibited neuromuscular (extrapyramidal) reactions which closely resemble parkinsonism. Such symptoms are reversible and usually disappear within a short time after the dosage has been decreased or the drug temporarily withdrawn. These reactions can also be controlled by the concomitant administration of an anti-parkinsonism agent (see *Physicians' Desk Reference*). Depending on the severity of the symptoms, suitable supportive measures such as maintaining a clear airway and adequate hydration should be employed. When 'Thorazine' is reinstituted, it should be at a lower dosage.

Lactation: Moderate engorgement of the breast with lactation has been observed in female patients receiving very large doses of 'Thorazine'. This is a transitory condition which disappears on reduction of dosage or withdrawal of the drug.

CONTRAINDICATIONS

'Thorazine' is contraindicated in comatose states due to central nervous system depressants (alcohol, barbiturates, narcotics, etc.) and also in patients under the influence of large amounts of barbiturates or narcotics.

SUPPLIED

Tablets, 10 mg., 25 mg., 50 mg. and 100 mg., in bottles of 50 500 and 5000; 200 mg., for use in mental hospitals, in bottles of 500 and 5000. (Each tablet contains 10 mg., 25 mg., 50 mg., 100 mg., or 200 mg. of chlorpromazine hydrochloride.)

Spansule® capsules, 30 mg., 75 mg., 150 mg. and 200 mg., in bottles of 30, 250 and 1500; also 300 mg., in bottles of 30 and 1500. (Each 'Spansule' capsule contains 30 mg., 75 mg., 150 mg., 200 mg., or 300 mg. of chlorpromazine hydrochloride.)

Ampuls, 1 cc. and 2 cc. (25 mg./cc.), in boxes of 6, 100 and 500. (Each cc. contains, in aqueous solution, 25 mg. of chlorpromazine hydrochloride; 2 mg. of ascorbic acid; 1 mg. of sodium bisulfite; 1 mg. of sodium sulfite; 6 mg. of sodium chloride.)

Multiple-dose Vials, 10 cc. (25 mg./cc.), in boxes of 1, 20 and 100. (Each cc. contains, in aqueous solution, 25 mg. of chlorpromazine hydrochloride; 2 mg. of ascorbic acid; 1 mg. of sodium bisulfite; 1 mg. of sodium sulfite; 1 mg. of sodium chloride; 2% benzyl alcohol as preservative.)

Syrup, 10 mg./teaspoonful (5 cc.), in 4 fl. oz. bottles. (Each 5 cc. contains 10 mg. of chlorpromazine hydrochloride.)

Suppositories, 25 mg. and 100 mg., in boxes of 6. (Each suppository contains 25 mg. or 100 mg. of chlorpromazine; glycerin, glyceryl monopalmitate, glyceryl monostearate, hydrogenated cocoanut oil fatty acids, hydrogenated palm kernel oil fatty acids, lecithin.)

Concentrate (for hospital use), 30 mg./cc., in 4 fl. oz. bottles, in cartons of 12 and 36, and in gallon bottles. (Each cc. contains 30 mg. of chlorpromazine hydrochloride.)

---

*'Levophed' and 'Neo-Synephrine' are the trademarks (Reg. U.S. Pat. Off.) of Winthrop Laboratories for its brands of levartrenol and phenylephrine respectively.



To help you and your family build systematically and surely for the future

A new type of trust service from Industrial National Bank

THE BUDGET TRUST

NOW INDUSTRIAL NATIONAL offers you a personal budget plan to help you build for the future — a budget plan you can start on right now! It's a new type of trust service — *The Budget Trust*.

How your Budget Trust works

You start your Budget Trust with $100 or more. Then you make regular planned deposits. It may be as little as $25 a month.

Your funds are invested in common stocks selected primarily with an eye to long-term growth rather than current income. Your lawyer draws the Trust Agreement — and Industrial National acts as your trustee. All income earned is added to your Budget Trust and reinvested. The continuous inflow of funds gives you the maximum advantage of dollar-cost-averaging.

Flexibility of your Budget Trust

Your Budget Trust is revocable at any time, in part or in whole. You may withdraw any part of your funds on quarterly withdrawal and entry dates.

You will discover, though, that a Budget Trust — with its systematic deposit feature — will make it much easier for you to accumulate the funds you need for your long-range goals. It's something important to consider when you think ahead to your retirement, your children's education, or any other years-from-now project.

Your Budget Trust brings you the benefits of Industrial National's broad investment and trust experience. One of our trust officers will be glad to discuss the new Budget Trust with you. To learn more about the Budget Trust, visit any Industrial National office, or call Mr. Allingham at JA 1-9700.

INDUSTRIAL
NATIONAL BANK OF
RHODE ISLAND

45 Neighborhood Offices Serving Rhode Island

Member Federal Reserve System
Member Federal Deposit Insurance Corporation

For the irritable G.I. tract

Milpath acts quickly to suppress hypermotility, hypersecretion, pain and spasm, and to allay anxiety and tension with minimal side effects.

AVAILABLE IN TWO POTENCIES

MILPATH-400—Yellow, scored tablets of 400 mg. Miltown (meprobamate) and 25 mg. tridihexethyl chloride.
Bottle of 50.

Dosage: 1 tablet t.i.d. at mealtime and 2 at bedtime.

MILPATH-200—Yellow, coated tablets of 200 mg. Miltown (meprobamate) and 25 mg. tridihexethyl chloride.
Bottle of 50.

Dosage: 1 or 2 tablets t.i.d. at mealtime and 2 at bedtime.

Milpath®

®Miltown + *anticholinergic*

WALLACE LABORATORIES *Cranbury, N. J.*

asthma attack averted
. . . in minutes

patient protected
. . . for hours





Nephenalin®

(the dual-action anti-asthmatic tablet)

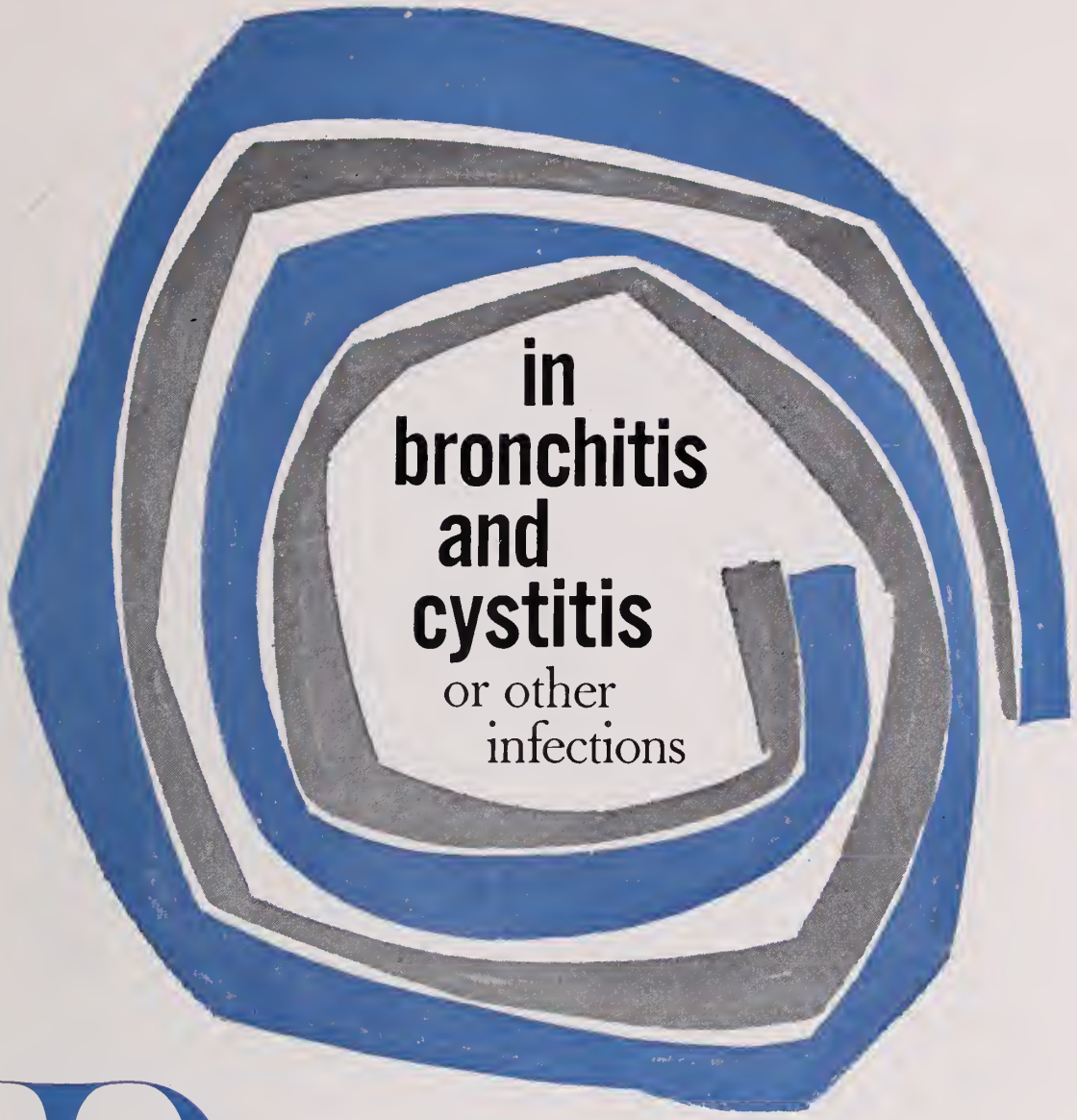
. . . works with nebulizer speed—provides four-hour protection

One NEPHENALIN tablet provides: *air in a hurry*—through sublingual isoproterenol HCl, 10 mg. *air for hours*—through theophylline, 2 gr.; ephedrine, ⅜ gr.; phenobarbital, ⅛ gr.

Dosage: Hold one NEPHENALIN tablet under the tongue for five minutes to abort the asthmatic attack promptly. Then swallow the tablet core for four full hours' protection against further attack. Only one tablet should be taken every four hours. No more than five tablets in 24 hours.

Supplied: Bottles of 50 tablets. For children: NEPHENALIN Pediatric, bottles of 50 tablets.

Caution: Do not administer NEPHENALIN with epinephrine. The two medications may be alternated at 4-hour intervals. NEPHENALIN should be administered with caution to patients with hyperthyroidism, acute coronary disease, cardiac asthma, limited cardiac reserve, acute myocardial damage, and to those hypersensitive to sympathomimetic amines. Phenobarbital may be habit forming. THOS. LEEMING & CO., INC., New York 17, N.Y.



antibiotic therapy with an added measure of protection

DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE LEDERLE

against relapse—up to 6 days' activity on 4 days' dosage
against secondary infection—sustained high activity levels
against "problem" pathogens—positive broad-spectrum antibiosis

CAPSULES, 150 mg., 75 mg. — PEDIATRIC DROPS, 60 mg./cc. — SYRUP, 75 mg./5 cc.

Request complete information on indications, dosage, precautions and contraindications from your Lederle representative or write to Medical Advisory Department.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

"The first prescription I ever wrote was for 'Empirin' with Codeine...



and it is still my stand-by for pain relief today."

PICTURE THE YOUNG DOCTOR with his first private patient, about thirty-five years ago. This is the moment, after years of study and guidance in classroom and at hospital bedside, when he assumes the full weight of responsibility for the well-being of his patient. He makes his diagnosis. The patient is in considerable pain, and his first concern is to relieve this discomfort. He writes a prescription for a new analgesic, a convenient drug combination that he believes will be of help. This patient (and many others to follow) finds gratifying relief, and the physician continues to rely upon this medication as the years go by.

Could this have been you in the 1920's? That was when 'Empirin' Compound with Codeine first came into general use (although plain 'Empirin' Compound has been well-known since the influenza epidemic of 1918). Satisfaction through the years has prompted doctors everywhere to depend on 'Empirin' with Codeine for relief of most all degrees of pain. For with this well-tolerated, reliable analgesic combination you can be sure of results, and feel secure in the fact that the liability of addiction is negligible.

Please accept our thanks for continuing to place your trust in a product that has been used more widely in medicine each year for the past four decades.

'EMPIRIN' COMPOUND with CODEINE PHOSPHATE*

Acetophenetidin, gr. 2½
Acetylsalicylic Acid, gr. 3½
Caffeine, gr. ½

Remember there are now four strengths available...

No. 1 – gr. ⅛
No. 2 – gr. ¼
No. 3 – gr. ½
No. 4 – gr. 1

*Warning—May be habit-forming.
Subject to Federal Narcotic Regulations.



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.



Today's little "limey" needs a half barrel of orange juice

...or, to be exact, a total of 2,106 ounces in his first two years. And how much he'll need during his first twenty years would have to be measured by the truckload, because the need for the nutrients contained in Florida orange juice continues throughout life.

How our little "limey" or any of your other patients obtain the vitamins and nutrients found in citrus fruits is important to them and to you. There are so many wrong ways, so many substitutes and imitations for the real thing.

For a way that combines real nutrition with real pleasure, there's nothing better than the oranges and grapefruit ripened under Florida's own sunshine. Somehow, nothing can surpass the result of the combination of sun, air, temperature, and soil found in Florida.

It's good nutrition to encourage people to drink orange juice. It's even more judicious to encourage them to drink the juices and eat the fruits watched over by the Florida Citrus Commission. These men set the world's highest standards of quality in fresh, frozen, canned, or cartoned citrus fruits and juices.

When you suggest to your patients that they have a big glass of orange juice for breakfast, or for a snack, or when they want to raid the refrigerator, the deliciousness of Florida orange juice will give you assurance that they'll *want* to carry out your recommendation. You'll be helping them to the finest drink there is—by the glassful or the barrel.

© Florida Citrus Commission, Lakeland, Florida

INDICATION: *Respiratory tract disorder*



Sinusitis

INDICATED: Chymoral®

controls inflammation and edema in respiratory tract disorders [1-4]

Chymoral reduces inflammation and edema of the nasal and sinal mucosa,[1, 2] thereby relieving engorgement of nasal turbinates and encouraging free drainage. By suppressing inflammatory reaction of bronchiolar tissue, Chymoral acts to liquefy thickened bronchial secretions and affords easier expectoration of mucus plugs. Taub[3] obtained very satisfactory control of congestive symptoms in a series of 48 bronchial asthma patients. Another group, with chronic diffuse obstructive emphysema, were afforded excellent relief.[1] Clinically, patients have said that they are not so short winded. Their endurance is better and they can expectorate more easily without the severe racking cough.

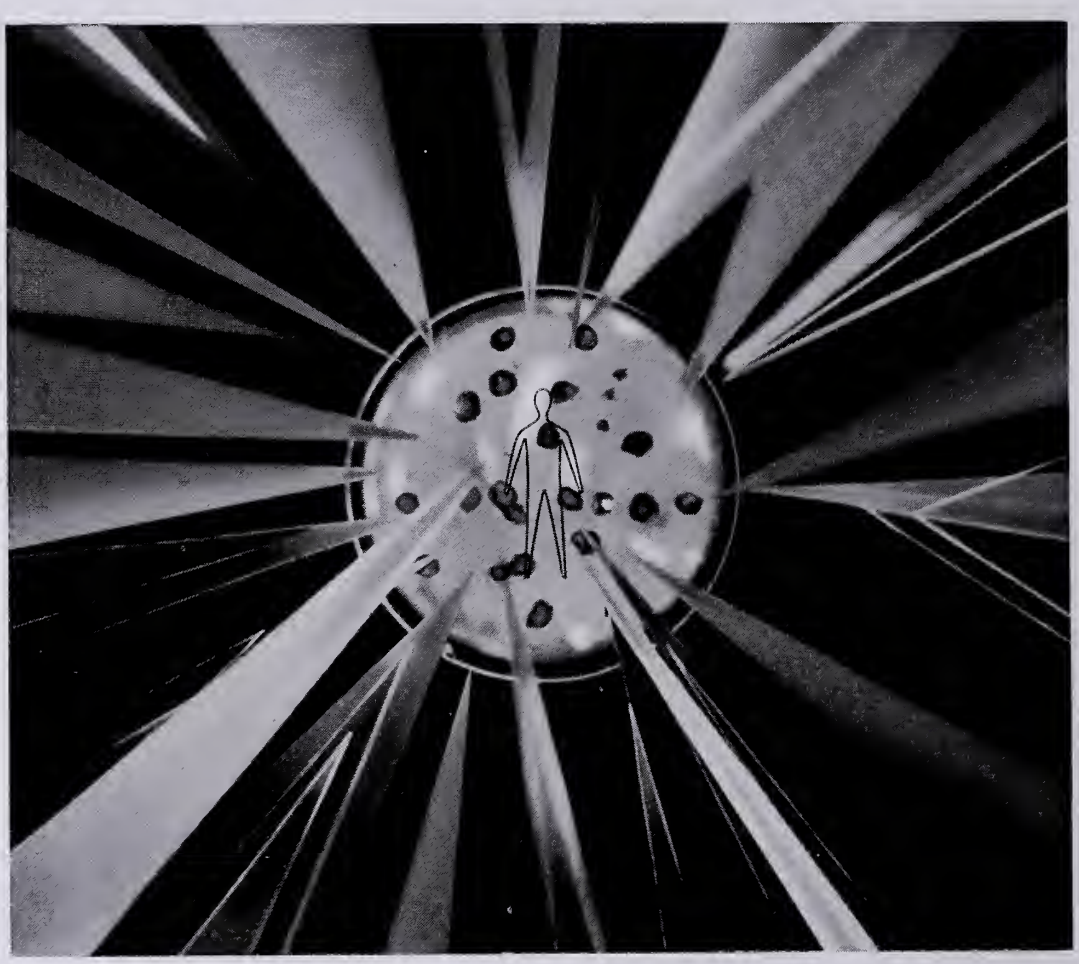
1. Clinical reports to the Medical Department, Armour Pharmaceutical Company, 1960. 2. Billow, B. W., *et al.*: Southwestern Med. *41*:286, 1960. 3. Taub, S. J.: Clin. Med. *7*:2575, 1960. 4. Teitel, L. H., *et al.*: Indust. Med. *29*:150, 1960.

CHYMORAL

Chymoral is an ORAL anti-inflammatory enzyme tablet specifically formulated for intestinal absorption. Each tablet provides enzymatic activity, equivalent to 50,000 Armour Units, supplied by a purified concentrate which has specific trypsin and chymotrypsin activity in a ratio of approximately six to one. ACTION: Reduces inflammation of all types; reduces and prevents edema except that of cardiac or renal origin; hastens absorption of blood and lymph extravasates; helps to liquefy thick tenacious mucous secretions; improves regional circulation; promotes healing; reduces pain. INDICATIONS: Chymoral is indicated in respiratory conditions such as asthma, bronchitis, rhinitis, sinusitis; in accidental trauma to speed absorption of hematoma, bruises, and contusions; in inflammatory dermatoses to ameliorate acute inflammation in conjunction with standard therapies; in gynecologic conditions such as pelvic inflammatory disease and mastitis; in obstetrics as episiotomies and breast engorgement; in surgical procedures as biopsies, hernia repairs, hemorrhoidectomies, mammectomies, phlebitis and thrombophlebitis; in genitourinary disorders as epididymitis, orchitis and prostatitis; in dental and oral surgery as fractures of the mandible or maxilla, difficult or multiple extractions, and alveolectomies. CONTRAINDICATIONS: None known. INCOMPATIBILITIES: None known. Antibiotics as well as generally accepted measures may be coadministered. SIDE EFFECTS: Mild gastric upsets, rarely encountered. DOSAGE: Recommended initial dose is two tablets q.i.d.; one tablet q.i.d. for maintenance. SUPPLIED: Bottles of 48 and 250 tablets.

ARMOUR PHARMACEUTICAL COMPANY KANKAKEE, ILLINOIS • *Originators of Listica®*

CHYMORAL *ORAL systemic anti-inflammatory enzyme tablet*



Why do we say Mysteclin-F is decisive in infection?

because...it contains phosphate-potentiated tetracycline
for prompt, dependable broad spectrum antibacterial action.

because...it contains Fungizone, the antifungal antibiotic,
to prevent monilial overgrowth in the gastrointestinal tract.

Mysteclin-F resolves many respiratory, genitourinary and gastrointestinal infections—as well as such other conditions as cellulitis, bacterial endocarditis, furunculosis, otitis media, peritonitis, and septicemia. It combats a truly wide range of pathogenic organisms: gram-positive and gram-negative bacteria, spirochetes, rickettsias, viruses of the psittacosis-lymphogranuloma-trachoma group.

Available as: Mysteclin-F Capsules (250 mg./50 mg.) Mysteclin-F Half Strength Capsules (125 mg./25 mg.) Mysteclin-F for Syrup (125 mg./25 mg. per 5 cc.) Mysteclin-F for Aqueous Drops (100 mg./20 mg. per cc.)
'Mysteclin'®, 'Sumycin'® and 'Fungizone'® are Squibb trademarks.

Mysteclin-F

For full information, see your Squibb Product Reference or Product Brief.

SQUIBB *Squibb Quality— the Priceless Ingredient*

Squibb Phosphate-Potentiated Tetracycline (SUMYCIN) *plus* Amphotericin B (FUNGIZONE)

"How do you feel lately, Mrs. K?" *"Well, Doctor, some customers still 'get on my nerves'... but somehow this doesn't bother me as much... I feel better now and people seem easier to get along with..."* "Feel sleepy?" *"No, nothing like that."*

In the treatment of mild to moderate tension and anxiety, the normalizing effect of TREPIDONE leaves the patient emotionally stable, mentally alert. Adult dose: One 400 mg. tablet, four times daily. Supplied: Half-scored tablets, 400 mg., bottle of 50.

this could be your "anxiety patient" on

TREPIDONE®

MEPHENOXALONE LEDERLE

Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle



The revolutionary discovery that simulates breast feeding.....



Natural nursing action nipple *induces even sucking that dramatically lessens outside air swallowing and makes baby exercise his jaws. Designed to avert tongue-thrusting and other malocclusions not inhibited by conventional nipples.*

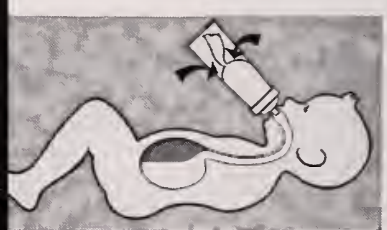


Because the disposable bottle is pre-sterilized, it *eliminates the possibility of contamination through improperly sterilized bottles.*





With conventional bottle *air has to get inside bottle for milk to come out. Nipple often collapses and baby has to suck harder, so more air gets into his stomach. Both overfeeding and underfeeding can ensue, along with the aerophagia and flatulence which can produce colic, spitting up, and after feeding distress.*



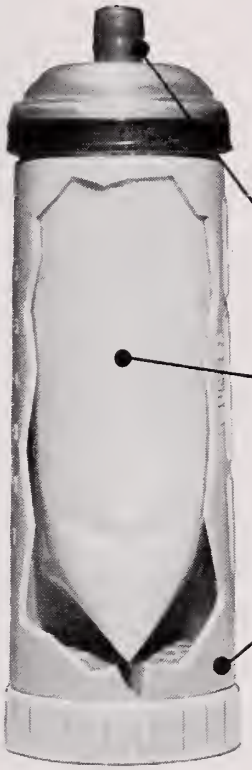
Natural design nipple *of Playtex Nurser assures even flow. Its pliable inner bottle contracts with atmospheric pressure as formula is consumed. Baby takes more nourishing formula, less swallowed air to cause discomforting spitting up and colic.*

dramatically reduces spitting up and colic

To the members of the medical profession who recognize the advantages of breast feeding—here's a completely new concept in baby feeding that all doctors will welcome. The new Playtex Nurser. It features a soft, pre-sterilized inner bottle which is disposable, and a broad, non-collapsing nipple which produces a sucking action similar to that in breast feeding.

Because the outside atmospheric air pressure contracts the soft inner bottle, the formula is withdrawn more naturally than with conventional rigid baby bottles. There is no vacuum formation to set up air blocks. The natural-action nipple induces sucking which makes for less air swallowing, and less spitting up—and in so doing, promotes the healthful mouth-jaw exercises the mother's breast provides.

Colicky infants, problem feeders and premature babies especially will benefit from the breast-like action of the new Playtex Nurser. The fact that the bottle is pre-sterilized and disposable will appeal to mothers who do not breast feed their babies. The fact that the Nurser does so closely simulate breast feeding will be similarly important to the health of any baby fed with it.



(Cut-out View)

"Nature's Way"

PLAYTEX NURSER

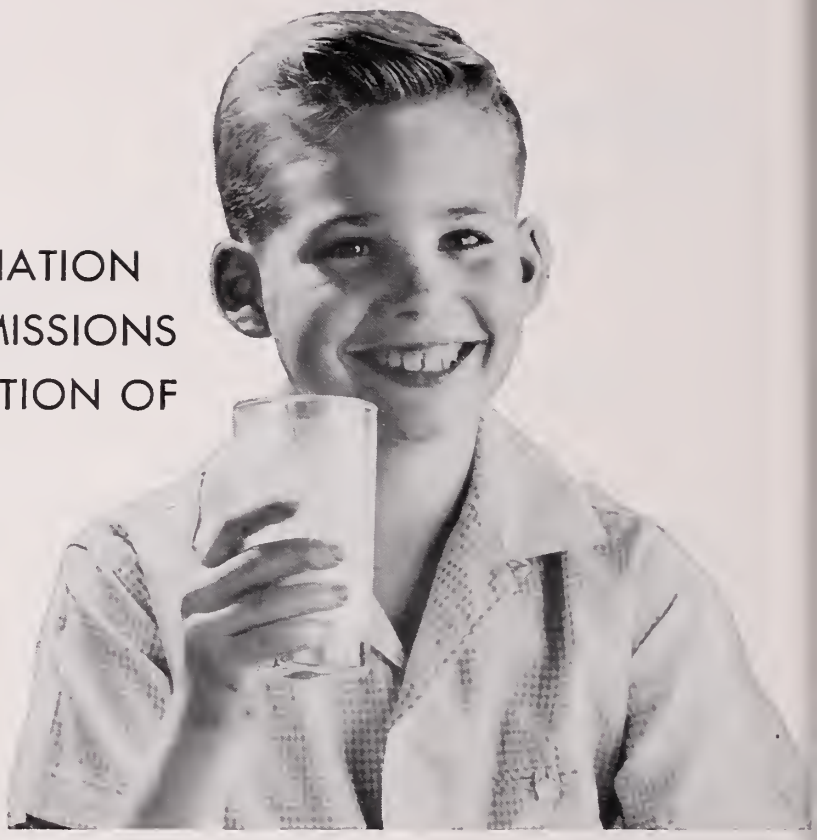
"The nearest approach to breast feeding"

©1961 by International Latex Corporation

Certified MILK

THE AMERICAN ASSOCIATION OF MEDICAL MILK COMMISSIONS SUPERVISES THE PRODUCTION OF

Certified MILK



1. CLEANER. Lowest bacteria-count. Milk checked before each milking. All utensils, bottles, and equipment sterilized before use.

2. BETTER-PROTECTED. Strictest medical supervision of herds and employees. Frequent examinations and laboratory-control AT THE FARM are required.

3. AUTOMATIC MILKING. Cows are milked automatically by electric machine. Milk is bottled without exposure to air or human touch.

4. BOTTLE CLOSURES. Must be of the highest quality to provide complete protection for the milk and bear approval of The American Association of Medical Milk Commissions.

5. MORE NUTRITIOUS. Cows scientifically fed balanced ration. Nutrition control from soil to delivery of milk. Same diet all year.

6. LONGER-LASTING, BETTER-TASTING. Diet control, special handling, and shortest time of delivery from cow to consumer assure fine fresh flavor that lasts for weeks.

7. THE DOCTOR'S MILK. Produced, processed, bottled on farms supervised by Medical Milk Commissions. Each bottle bears the seal of the A.A.M.M.C. and names of the supervising Commission and producing farm.

MILK COMMISSION OF PROVIDENCE MEDICAL ASSOCIATION

HILLSIDE FARMS, INC., 1308 Phenix Ave., Cranston, WI 2-3400
Produced at Hillside Farm, Cranston, R. I.

H. P. HOOD & SONS, 135 Harris Ave., Providence, DE 1-3024
Produced at Hood Certified Farm, Beverly, Mass.

WHITING MILK CO., 40 Tockwotton St., Providence, GA 1-5363
Produced at Hampshire Hills Farm, Wilton, N. H.

AN AMES CLINIQUICK®
CLINICAL BRIEFS FOR MODERN PRACTICE

the diabetic with proteinuria!



Protein in the diabetic patient's urine is usually cause for concern to the physician. He begins to think in terms of renal damage. This generally calls for a re-evaluation of the patient's diabetic state; in particular, his degree of diabetic control. Loss of control is a major factor in the development of degenerative nephropathy.

However, in the diabetic patient, proteinuria also may be indicative of disorders unrelated to the diabetic state. *Postrenal* disturbances such as lithiasis, cystitis, pyelitis, bilharziasis or prostatic impairment may produce protein in the urine. *Renal* proteinuria may be due to predisposing factors such as abscess, carbuncle or gangrene. These are usually of a transitory nature. When diabetes is the only apparent contributing factor to the presence of persistent proteinuria ("diabetic proteinuria"), renal damage associated with degenerative diabetic nephropathy is usually indicated.*

*Nagy El Mahallawy, M., and Sabour, M. S.: J.A.M.A. *173*:1783 (Aug. 20) 1960.

One of the simplest and most reliable means of evaluating the diabetic is through daily urine testing with URISTIX® for both *glucose* and *protein*—to indicate diabetic control, and forewarn of possible renal damage. Following a simple "dip-and-read" technique, URISTIX provides these *two* important test results *in just ten seconds*. Thus, it eliminates delay, guesswork, and fussing with equipment...making it equally valuable for office diagnosis or home testing.

to facilitate diabetic evaluation...

URISTIX®

BRAND *Reagent Strips*

colorimetric "dip-and-read" combination test for both *proteinuria* and *glucosuria*

- 1 dip...10 seconds...2 readings
- standardized color chart for dependable estimations
- unaffected by turbidity, drug metabolites, non-glucose reducing substances

available: URISTIX Reagent Strips, bottles of 125.

AMES
COMPANY, INC
Elkhart • Indiana
Toronto • Canada

00561



LOMOTIL®

(brand of diphenoxylate hydrochloride with atropine sulfate)

lowers motility
controls diarrhea

Lomotil brings prompt symptomatic control in diarrhea, either acute or chronic.

Both pharmacologic and clinical evidence indicate that Lomotil selectively lowers the propulsive component of gastrointestinal motility without relaxing intestinal sphincters. So efficient is this action that studies in mice have shown Lomotil to be effectively antidiarrheal in one-eleventh the dosage of morphine.

Such striking antidiarrheal activity strongly suggests that Lomotil is the drug of *first* choice for prompt and positive control of diarrhea.

Dosage: The recommended initial dosage for adults is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is under control. Maintenance dosage may be as low as two tablets daily. Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg., each containing 0.025 mg. of atropine sulfate to discourage deliberate overdosage. Recommended dosage schedules should not be exceeded.

An exempt preparation under Federal Narcotic Law.

Descriptive literature and directions for use available in Physicians' Product Brochure No. 81 from G. D. Searle & Co., P.O. Box 5110, Chicago 80, Illinois.

G. D. SEARLE & CO.
CHICAGO 80, ILLINOIS
Research in the Service of Medicine

The RHODE ISLAND MEDICAL JOURNAL

VOL. XLV JANUARY, 1962 NO. 1

SOME PRACTICAL CHALLENGES TO MODERN MEDICINE*

JUSTICE JOSEPH R. WEISBERGER

The Author. *Honorable Joseph R. Weisberger of East Providence, Rhode Island. Justice, Superior Court of Rhode Island.*

WHEN I WAS ASKED to speak upon this occasion some time ago, I began to speculate, and am probably still preoccupied with speculation, as to my qualifications in any way to address this distinguished gathering on challenges to the medical profession. After having heard Doctor Dawe and Commissioner Smith speak from their vast fund of experience in this field, I am even more at a loss than ever to determine what contribution I could possibly make.

However, I have come to one tentative conclusion. Since the filing of the King-Anderson Bill and the Forand Bill which preceded it, and since some difficulties have arisen between the medical profession as represented by boards of directors and so on, on various Blue Shield Plans with some of the public regulatory agencies, perhaps the medical profession has feared that its public image is diminishing. And as a matter of comfort, it wanted to take a look for a short time at a member of a profession which is conceded to be more unpopular than that of any other in the United States. In fact, I suppose it can be illustrated by a story that I've told many times before regarding the public image of a member of the legal profession. You know, shortly after World War II, a transport was coming back to the United States and struck one of the then ubiquitous floating mines. Everybody aboard the transport was a victim of this terrible tragedy except three men. And these three men were found clinging to a life raft upon which they managed to clamber after the tragedy had occurred. One was a clergyman, the other was a member of the medical profession, and the third in civilian life had been a lawyer. So they floated for days until finally they were out of food and they were out of water — the little supplies in the life raft had been exhausted. And then one day they saw on the horizon a blur that appeared to be land. Well, after floating for a time they were certain it was land. And at that point they knew that the forces of wind and tide would not suffice — that one of them would have to swim to shore and get help and the other two would stay aboard and do what they could. Well, they drew straws for this, and as luck would have it, the lawyer drew the short straw. So after bidding farewell to his two companions, he lept into the water and began to strike out earnestly for the distant shore. At that point a school of sharks began to circle around him. Well, the clergyman got down on his knees and prayed and prayed, and finally lo and behold, the school of sharks parted and the lawyer swam through unmolested. So the clergyman looked at the physician and said, "Now, man of science, you see what the power of prayer can do." The physician looked back with somewhat of a cynical shrug and said, "Prayer, hell. That's just professional courtesy."

I suppose I can say that one who has been fortu-

continued on next page

*Presented at the New England Blue Shield Professional Relations Seminar held at the Colony Motor Inn, Cranston, Rhode Island, September 22, 1961.

This issue has been devoted largely to the publication of various papers presented at the New England Blue Shield Professional Relations Seminar held at Cranston, Rhode Island, on September 22, 1961.

While this Journal may take strong issue with some of the views expressed, these essays are nevertheless sufficiently provocative to justify making them available to the profession at large. We are doing so for the information of our readers and as a service to them. We urge that they be read carefully and thoughtfully.

THE EDITORS

nate enough to attain judicial office is in no way surprised at the unpopularity which was his birthright at least 'til the time he was sworn in as a member of the bar. But you also know that this feeling in regard to lawyers has been aided and abetted from time immemorial by playwrights, novelists, and, of late, scenario writers for TV programs. All you have to do is switch your dial and you find out that the picture of the lawyer is constantly being presented to you. On the westerns that we see so often on television, he's always the fellow who has bought up all the water rights and closed the settlers off from watering their cattle. If he doesn't do that, he probably runs the local saloon and a crooked faro table at that. And, they usually have a judge, too. He is a very senile fellow whom you are led to believe once saw better days. He can't read or write, but he does have a fancy checkered waistcoat liberally sprinkled with his over-abundant repasts all at the expense of his lawyer who advises the local gang. Well now, this is the picture that is constantly being presented of the legal profession. And I suppose that the medical profession, if it consults with the geniuses of Madison Avenue, are perhaps somewhat worried about their public image. So, whom better could you select to advise you in respect to your own public image than one who belongs to a profession that from the time of Shakespeare has been heaped with abuse.

I perhaps can't tell you any way significantly to improve, but I can perhaps advise you as to some of the ways in which you can live with it. However, I do not intend to take your time with a semi-humorous analysis of the reasons why the legal profession has had such a poor public relation over the years. There are many reasons for that, and I could probably talk to you for an hour or more, but you wouldn't be interested in that subject.

I do, however, feel that the medical profession starts off a lot better than has the legal profession. At least for many centuries the medical profession has had good public relations. The medical profession has been extolled in song, story, drama, as a group of dedicated and selfless individuals who seek to protect the health of the community, who seek to fight man's common enemy, disease. Of course, this is the reason that you start out so well. For in the law there is always the conflicting adversary situation. No matter how conscientiously the lawyer or the judge proceeds, at least 50 per cent of the parties of the litigation are bound to turn out to be disappointed. Whereas in your dealings with the public, in your fight against disease, in your fight against the great reaper itself, you are not faced with such problems.

However, there are certain practical talents, not only to this wonderful public interest which the medical profession has attained, but also to the continual private practice of medicine as we have known it. And perhaps, apart from my belonging to this other profession which I have mentioned, it may be that those who were determining the make-up of this program felt that I might represent the public in giving you the unbiased view of one who has very little practical experience with Blue Cross, Blue Shield, its regulations, its actuarial policies, save as an ordinary member of the public who is a subscriber to both of the plans, and members of whose family have benefited from both of these plans.

Over the past half century, the tremendous improvements in the practice of medicine, the tremendous inroads which have been made against the traditional killers, the epidemic type of illness, has been nothing short of miraculous, and perhaps, as Commissioner Francis R. Smith of Pennsylvania has indicated, in this strength lies something of a weakness.

At the present time, I have no doubt that general practitioners in the state of Rhode Island or the New England states generally, are probably carrying out procedures as a matter of routine, and administering treatment to their patients which would have been regarded as revolutionary a quarter of a century ago, in such medical centers as Vienna and Edinburgh. At the present time, the average medical practitioner has reached a level of competence which, a half century ago, would have been beyond the wildest hopes or dreams of the profession itself and its most advanced and cultivated members.

This is an aspect of which I do not think the average citizen is unaware. We all remember the physician of our boyhood, the lordly, all-knowing, competent and intelligent man whose mere presence in the sick room made the patient feel 75 per cent better. This hasn't changed, it has grown even greater.

The practice of medicine remains an art in the truest sense of the word. The determination, the application of the scientific knowledge which has come into the hands of the average physician requires tremendous knowledge, tremendous training, tremendous background, and careful intelligence in order to carry on. Now, of course, at this same time throughout the world, there have been other happenings. There have been other advances, and memorable among these occurrences is what has been termed a revolution of increased expectation throughout the world.

We see the manifestations of this revolution as it has occurred in Africa. The rise of the new State, the insistence of the average person who is underprivileged and has been underprivileged for all the

millennia of time, that he be given that which he considers to be his birthright. He wants more. He insists upon more. And he will go to great lengths to assure himself of more. Standards have increased in every segment, not only of our national life, but in every segment of life throughout the world.

And in the forefront of this increase in standards has been the increase of competence of the medical profession, particularly in the United States. And going hand in hand with this increase in competence has come about a necessary increase in resources, increase in equipment, increase in the number and variety and expense of facilities today. I think that Commissioner Smith said something that is irrefutable when he mentioned that the problems of Blue Shield and Blue Cross were inestimably intertwined. There is no question that the practice of medicine and the availability of hospital facilities go hand in hand. And that by the same token, economic prospects of the practice of medicine and the dispensation of hospital care go hand in hand as well.

Now what is this great problem which we presently face? I think that the problem has to be viewed in terms of people. The problem must be viewed in terms of its impact upon the average man and the average woman. As we all know, in the United States, great attention has been given to the satisfaction of human needs. We are all most proud to be able to say that our people have attained the highest standards of living ever known in the entire history of the world. We are delighted that our people are able in many instances to have at least one or maybe two automobiles. And that they aspire to the ownership of their homes, that they aspire to greater and more full education for their youth.

But our people have a great penchant and desire which perhaps stems from the great depression of the 1930's for security. And the people of whom I speak are not those who are characteristically indigent, nor indeed am I speaking of that group which has great resources and great wealth — a small group indeed. But of the vast bulk of the middle class, the one who takes on an extra job so that he can add another bedroom to his house, so that his son and daughter may have an opportunity to go to college as he did not. And beyond that, the professional men like yourselves who have a reasonable income. These people are most security minded and are most interested in being able to support themselves, to walk in dignity regardless of the unexpected tragedy that may cloud their lives. Now such an individual who owns his own home, who has always paid his own way, is haunted by the spectre of what will happen to him in the event that he has a serious illness. How will he pay the bills? And lately he has become quite preoccupied with the problem of what does he do when his aged mother or father requires extended medical care and extended hospitalization. This is a crushing problem to the great bulk of those who belong to the middle class.

And the American people have evolved a certain technique to try to take care of unexpected tragedy. Many, many years ago, well over a century ago, was evolved the idea of insurance — spread the risk. The individual attempts, by periodic payments which are within his ability, to forestall the tragedy that might sweep away the work of a lifetime. And at the same time, if he becomes dissatisfied with his own ability to spread the risk by means of insurance, by means of combination with his fellow on an informal basis, so far as he is concerned, he is also quite prepared to ask the intervention of his benevolent government. In the United States the term "Uncle Sam"— though it perhaps originated from other basic motives and reasons — has come to be a most benign figure indeed. Uncle Sam is truly our uncle. And many of our people are quite prepared to resort to him to take over the responsibilities which they do not feel they can bear. Now at the same time, while he resorts to uncle, and while uncle is benevolent and well intentioned and has the best motives in the world, the average John Q. American knows that uncle has other characteristics. Uncle is benevolent, but uncle is often inefficient. Uncle has a big appetite and he does everything in a grand manner, and he has to do that because with 180 million nieces and nephews how can he do it any other way? You must do it in a grand manner.

So that the average American of whom I speak, this individual who isn't quite as rugged as he used to be but still an individual, is reluctant to resort to Uncle Sam, unless he becomes convinced that there is no recourse in the field of private enterprise to meet his needs. I don't think the average citizen has any desire to change his relationship with his physician. I think he's more than satisfied with it, by and large. He will criticize one physician perhaps. Perhaps personality clashes may arise, but these are worked out within the system. If he doesn't like one, he'll go to another. And I think he realizes that he is probably getting the finest care that any person ever received in the history of the world. But he is obviously worried about paying the bills — greatly worried. And I don't think the physician is entirely unaware of his worry, because if he were inclined to be a little opaque in this direction, his patients would certainly inform him frequently that the problem existed. And yet, here we have the patient worried about the economics of medical care and the doctor aware — most aware — of the economics of medical care, not only as they affect him, but as they affect his patients as well.

continued on next page

And we hear some talk about abuses, and I have no way of knowing whether these abuses exist or they do not. I have no experience in this field; I have taken no surveys; I'm completely unaware of what a statistical analysis would disclose. But let's look at the abuses for a moment. How they might arise, and whether they are abuses always; maybe some are not. Having mentioned the tremendous advance in medical competence and medical standards, we must also take into consideration that the practitioner, the physician, may not always be certain of his diagnosis. Fifty years ago, if the physician examined the patient and came to a conclusion based on the best he could do by putting his ears to the patient's chest and massaging certain places that might show certain things, looking him over, observing him for a while, that diagnosis was largely unquestioned, and if the patient died it was deemed to be inevitable. But nowadays if a patient comes to a physician with a stomach ache, and I'm saying this only illustratively because I have no competence here either, it may be a suggestion, it may require an entire GI series to tell what it really is. Suposing it's a persistent stomach ache, and the physician may have to put the patient through a great number of very expensive tests and analytical procedures. And if the physician himself is in doubt as to whether all of these are necessary, the standards of the profession being what they are, he feels obliged to rule out various possibilities that fifty years ago he would not even have considered. This costs money. Many times this requires hospitalization; and many times after the hospitalization and the diagnostic procedures and tests have been completed, the patient turns out to have indigestion.

Now, of course, we don't want to regard that as an abuse. It's not an abuse. It's careful medical practice. And where do you draw the line, as individual physicians, between careful medical practice and unnecessary use of hospital facilities? This is a problem that's not easy of solution, even to one who knows nothing about it, and usually things are quite easy of solution to those who know nothing about them. Though in Rhode Island malpractice suits are minor in number, and very few of them reach the courts, in other sections of the country I am sure that they have increased enormously; and I know that the reading of national literature, the reading of the journals of the American Medical Society, and various and sundry other publications of a national nature, circulated widely among the medical profession, has made them most aware of this problem lurking in the background. But many times the physician feels it incumbent upon himself to cover this possibility and that peril — even though it may be his opinion, if he were pressed for it — that the peril which he seeks to rule out may not exist. Can we say that that is an abuse? I don't suppose anyone would make it so.

However, it does require increased use of hospital facilities. It does require increased cost to the patient, and if there is an insurance plan, to such a plan.

Now, after listening to the very interesting and entertaining discourse of Doctor Edwin Lloyd Dawe, I am certain that every single person in this room would be unanimous in stating without equivocation that we do not want socialized medicine, as he described it in Britain, to occur here in the United States.

We all have had some experience with socialized medicine. I think most of us have. Those of us who had the opportunity to serve in the armed forces of the United States at any time have had some experience with what might be called socialized medicine. And let me hasten to say that the medical men with whom I had the honor to serve during my five years in the United States Navy were as fine and splendid a group as I have ever met. Many of you, I'm sure, were among them. It wasn't the medical practitioner, it wasn't the physicians, it wasn't the doctors, it was the system. The system made the kind of medical care which we desired, which we not only desired, but had demanded. That's why it was given to us — we demanded it. Anybody who has responded to a sick call at 0800 knows of what I speak. The herding of the patient before the officer who had the duty that day, in rapid sequence, I am sure did not result in the death of any individual, or at least not too many individuals who had serious ailments, but it certainly would be a blow to anyone's basic human dignity.

And I think that we Americans are interested in human dignity. We not only want our lives to be saved, but we want to be able to hold our heads up just a little bit in the process. And I am sure that there cannot be any great feeling of human dignity in the patients in the middle of the aisles in Florence Nightingale's old hospital so aptly described by Doctor Dawe.

So there is a public interest in the maintenance of the physician-patient relationship as we have known it. We want our own doctors whom we think of as the real thing. I don't mean to say that the impersonal staff, the salaried staff of the hospital wouldn't care; but it's not so apparent that they care. And I think enough of the dramatic aspect of the practice of medicine to believe it has helped many patients almost as much as the aspirin tablet.

But we have a public interest, not only an interest of your profession, in the maintenance of the private medical practice we have known. But how do we retain it? And I'm using the word "we" because I'm as interested in it as you are, and therefore, insofar as I am interested in the same ends, I become engaged in a joint venture with you to try

continued on page 29

THE BLUE SHIELD CHALLENGE*

FRANCIS R. SMITH

The Author. *Francis R. Smith, Insurance Commissioner of the Commonwealth of Pennsylvania.*

ON JUNE 29, 1960, the Medical Service Association of Pennsylvania, our Blue Shield Plan, filed with me, as insurance commissioner of the commonwealth of Pennsylvania a request to:

1. Increase certain of its subscription rates;
2. Revise certain of the fees in its fee schedule of payments to be made for services performed by doctors for Blue Shield subscribers;
3. Reduce the waiting period for obstetrical delivery services from 12 months to 9 months.

At the outset of the hearings legal counsel for Blue Shield formally objected to appearances entered for the cities of Scranton, Philadelphia and Pittsburgh and the United Steelworkers of America, A.F.L.-C.I.O., arguing that neither the administrative agency law nor the nonprofit Medical Service Corporation Act provided for the required public hearings with respect to Blue Shield filings. The objections of the filers were overruled and the hearings proceeded with the full participation of all who had entered their appearances.

I proceeded in this hearing upon the assumption that any decision I would thereafter render would be adjudged within the meaning of the administrative agency law. In order to render an adjudication I was obliged to hold hearings in accordance with the law.

In rendering the adjudication I was mindful of the effect it would have upon millions of citizens of Pennsylvania as well as upon the Blue Shield itself. One out of every three persons in Pennsylvania depends upon Blue Shield for protection against burdensome medical bills. More than 90 per cent of the doctors of medicine practicing in Pennsylvania actively participate in the Blue Shield program. Blue Shield in our state under highly competent management and with the collaboration of our five Blue Cross Plans has made vast attainments in providing the citizens of Pennsylvania with necessary health care at moderate cost. Because of these attainments Blue Shield has become vitally important to our citizens. The future of Blue Shield and the future of prepaid health care are therefore proper matters of serious concern to all the people of Pennsylvania.

The objects and purposes of Blue Shield become apparent when we recognize its origin and the legal basis of its continuing existence. The legislature of Pennsylvania in enacting the Nonprofit Medical, Osteopathic and Dental Service Corporation Act intended that persons of LOW INCOME should be provided medical, osteopathic and dental services at cost which they could reasonably afford through nonprofit enterprises acting for them in contracting with doctors to provide such persons with medical services for reasonable fees which doctors were certain to receive.

Time has proven that the legislature acted on an inherently sound premise. Doctors, being sure of receiving their fees, could afford to provide Blue Shield benefits at lower than normal charges. Subscribers could receive doctors' services for modest payments due to lower doctors' fees and due to the spreading of medical costs over many persons.

The legislature went a step further and publicly subsidized these nonprofit enterprises by making them tax exempt. The legislature was in effect stating that since the sole purpose of such organizations is to perform a public service free from all considerations of private gain, we will deny the commonwealth of Pennsylvania and each of its political subdivisions the normal rights of taxation with respect to their income and properties.

This action of the legislature, beyond any doubt, vests in the public an unquestioned interest in the Pennsylvania Blue Shield Plan. (Such an interest, incidentally, in itself, justifies the participation of city representatives in Blue Shield hearings.)

The legal status of Blue Shield as a nonprofit, tax exempt corporation vested by the legislature with the authority and if you please an obligation to perform a public service for our citizens, rebels against any opinion or attitude that Blue Shield exists for the special or primary benefit of any group apart from the general public, or that any special group has any moral or legal right to point Blue Shield in directions which they would have it move.

continued on next page

*Presented at the New England Blue Shield Professional Relations Seminar held at the Colony Motor Inn, Cranston, Rhode Island, September 22, 1961.

Blue Shield, doctors, and the general public must all recognize the great public purpose of Blue Shield, and the public obligations assumed by all who are in any direct way concerned or associated with Blue Shield. The Blue Shield plan owes an obligation to manage its affairs as a public-purpose, nonprofit enterprise responsive to the needs and views of the people. Doctors, by reason of their voluntary participation in Blue Shield, owe an obligation to promote Blue Shield's primary purpose of providing adequate medical services for subscribers at costs within their means. Accordingly, Blue Shield management and participating doctors must be constantly alert to remove or lessen any abuse that may exist in the use of Blue Shield benefits.

One basic impression I gained from these hearings is that the Blue Shield organization is more responsive to the views of doctors and the views of the medical society of the state of Pennsylvania than to the views of any other group. It was fully apparent during the hearing on Blue Shield's SENIOR CITIZEN AGREEMENT that the wishes of the Medical Society of the State of Pennsylvania determined the type of senior citizen program which Blue Shield offered for insurance department approval. Any views held by Blue Shield management were totally subordinated to the wishes of the State Medical Society. Blue Shield officials stated that the Pennsylvania Medical Society "told us what we should do" in regard to the fee schedule to be used in such a program. They also stated that "The Medical Society gave us a program and said 'We want your plan with a fee schedule,' and that off the bat sets the level of our payment."

It was pointed out by Blue Shield officials that the State Medical Society must have an important voice in such matters since doctors are relied upon to provide service benefits. It was admitted by Blue Shield, however, that persons or groups representing older people and other segments of the public were not consulted at all in the formulation of any aspect of the senior citizens' program.

The subordination of initiative and policy by Blue Shield to the Medical Society of the State of Pennsylvania is symptomatic, in my opinion, of a condition which is serious to the extent it exists.

I recognize that Section 510 of our Nonprofit Corporation Law requires that a majority of the members of Blue Shield be doctors of medicine. This fact alone, however, neither justifies nor does it contemplate that Blue Shield policy and operations be subordinated to the policies and programs of the State Medical Society. It certainly does not justify or contemplate that policy decisions will be made for Blue Shield by the Medical Society and summarily passed on to the Blue Shield organization for implementation. The organized medical profession has no more moral or legal right to control Blue Shield policies than does the Bar Association to control judicial and other offices occupied by members of the legal profession.

Blue Shield is not the doctors' plan; it is the public's plan. The doctors serving Blue Shield are fulfilling a trust embodied in them by the legislature. The nature of that trust is clearly stated in the enabling act. It is to provide "Adequate medical, osteopathic, and dental services to persons of low income who are unable to provide such services for themselves or their dependents without depriving themselves or their dependents of such necessaries of life as food, clothing, and shelter." In my opinion, Blue Shield, in its dealings with all groups, whether they be medical societies, labor organizations, subscriber groups, employer representatives, or others, must act as an independent public-purpose corporation which will not subordinate itself to any groups, but will generously work with all in fulfilling its great purpose.

Blue Shield plans face the greatest challenge of their history. That challenge is to provide ever-broadening medical care to citizens at costs which they can afford. If free voluntary effort through public-purpose organizations cannot meet this challenge the future of free medicine in America is in danger. The Pennsylvania Blue Shield plan in facing this challenge must have the sympathetic co-operation of all our doctors, employer representatives, labor representatives, subscriber groups, and the confidence of our general citizenry and its public representatives. To meet the challenge of the immediate future, Blue Shield must return to original and basic concepts. It must identify itself clearly and distinctly in the public mind as the agency empowered and directed by the legislature to bring adequate health services to our people at prices they can meet within their budgets. I am fearful that Blue Shield will have difficulties meeting this challenge if it retains its present close identity through board composition and policy with but one, though a very important, segment of society, the Medical Association.

On April 15, 1958, I rendered an adjudication with respect to requests from certain Blue Cross Plans in Pennsylvania for rate increases. In that adjudication, I noted the great amount of testimony which had been submitted concerning the existence of wasteful and unnecessary use of Blue Cross benefits and that all such abuses must inevitably be reflected in higher Blue Cross rates. I directed the Blue Cross Plans to take certain specific actions to minimize any over-utilization that might exist. I asked for the co-operation of medical societies, doctors, hospitals and the public with the efforts which I proposed to be undertaken by the Pennsylvania

Blue Cross Plans. I am pleased by the co-operative response of interested persons and organizations to that adjudication.

It is my firm conviction that within the framework of the law under which Blue Shield operates, there is ample latitude for Blue Shield to do much more than it has in co-operating with Blue Cross Plans, medical societies, hospitals, and the public in lessening unnecessary utilization of Blue Shield services. With the exception of diagnostic and emergency services provided in doctors' offices, practically all Blue Shield services are rendered in hospitals. If unnecessary hospital utilization is reduced, it should follow that a substantial amount of unnecessary utilization of Blue Shield services would also be reduced. It is therefore of the greatest interest to the public and to the Pennsylvania Blue Shield Plan, that unnecessary use of hospital facilities be eliminated wherever it exists. I strongly believe that great accomplishments in this effort can be made if Blue Shield places its moral and active support behind the medical review committees established through the co-operation of Blue Cross Plans and the medical societies. Furnishing of statistical data in the form of pure statistics to such review committees without resort to names of patients or doctors may be helpful to them in their review work. The formulation of such objective data would in no way constitute a restriction on doctors.

Blue Shield and Blue Cross coverage are inextricably connected, one with the other. Many subscribers fail to realize that two independent organizations are involved in providing such coverage. The public is rightfully concerned with the total cost of both Blue Cross and Blue Shield. Therefore, it is properly and vitally concerned with any impact which Blue Shield and Blue Cross have upon each other that results in unnecessary utilization of hospital and medical services.

So much for the setting so that you may understand the background of the Blue Shield.

The results of the adjudication were:

1. That certain increases in subscription rates were permitted.
2. The revisions in the fee schedules paid to doctors were turned down on the basis that no testimony had been introduced setting forth the criteria of standards which had been applied to determine whether upward revision of fees was proper and justified.

In effect, this second part of the filing relating to revision of doctors' fees requested me as insurance commissioner to approve the proposed upward revisions in payments to doctors merely on Blue Shield's word that they were fair and reasonable. An insurance commissioner fulfilling his public obligation must require that Blue Shield demonstrate by concrete evidence that such changes are proper and reasonable. This, I regret to say, was not done, and my contacts with other insurance commissioners suggests that this is a fairly common failing in such filings by Blue Shield. If the chairman of the Blue Shield fee schedule committee could not under direct testimony personally vouch for the fairness of the fees submitted to me, how could I then vouch for them before the general public of my state.

I directed that consideration be given to determine whether a totally revised fee schedule with generally lower fees reflected in lower subscription rates for full-service benefits can be developed for all citizens of Pennsylvania in the lower income groups without regard to their age. Efforts along this line would be in full keeping with the clear intent of the legislature in permitting the creation of Blue Shield as a nonprofit public-purpose corporation primarily for the benefit of low-income citizens.

As Americans we believe in free choice of doctor and hospital. This would seem to require per diem payment to hospitals and the fee system of payment to doctors. But you should know that there are many health organizations in the United States which have already abandoned such arrangements. Consider, for instance, many of the eminently successful labor health clinics. These are all served by physicians on salary. If hospitals are owned by such organizations, hospital support is provided on a budget, not a per diem or charges basis.

Under such set-ups, the limit of the insurance fund's liability is thus neatly determined in advance. If more service must be rendered than was anticipated the doctors and other health personnel must "make do" with budgeted funds. I emphasize this because it brings an understanding of an important aspect of the service benefits idea into sharper focus.

Service benefits to subscribers cannot be considered as a principle apart from contracts with hospitals and doctors. This must be understood by all who are involved — the public, the hospital people, and the doctors. Without such understanding the plans will be expected to perform miracles, to provide two-dollar service for a single dollar.

Without controls upon their subscribers' liability, willingly given by doctors out of recognition of a common interest to preserve private medicine, Blue Shield cannot solve the public problem. Let us never have to say of Blue Shield —"With doctors as its friends, who needs enemies!"

Let me open the door on this further. Society has given certain prerogatives to doctors and hospitals. It has tacitly agreed with doctors that it does not expect the rates they charge to be the same for all people, even for similar conditions. The man of

continued on next page

means may be charged whatever the doctor determines. Society will uphold — even insist upon — the doctor's right to collect the fee he alone determines. But in exchange for this prerogative, society has placed upon the man of medicine a responsibility to serve all who come for help regardless of ability to pay. The doctor's oath is such that he cannot withhold service from those who are unable to pay. We must bear in mind that there is a moral basis for the sliding scale of medical charges.

Prerogatives given by society are given on a string. They can be taken back at any time. This is an obvious but important point which hospital people and doctors must not overlook. It is your strength, but it is also your weakness. For as society organizes and develops insurance under which those of low income are enabled to pay reasonable premiums, the circumstances which required the sliding fee scale have been changed. It may therefore be expected that society's remedy for the imbalance which existed when it required free service for those of meager circumstances, the sliding scale of charges, will be altered to reflect modern reality.

I do not mean to say that all doctors see Blue Shield only from the point of view of the income it produced for them. These men and women are almost uniformly dedicated to relieving the sick. But most of them have never been required to consider the economic realities underlying Blue Shield. Only adequate public representation on the Board of Directors of Blue Shield can bring their eyes into focus.

The public wants protection against sickness bills; it is absorbed with the idea today. This goes beyond the cost of the hospitalized illness. It wants benefits and coverage which will provide the most health service for the health insurance dollar. It will not long continue to countenance forces that slice the value of that dollar and undercut the health insurance idea.

Once again I ask: How long will it stand for Blue Shield payment to doctors only when subscribers are hospitalized? The incentive to hospitalize all patients and create greater costs automatically is built into such a program. It is probably central to the misuse of Blue Cross benefits we hear more and more about. Let me read you a few paragraphs from a lead story in a recent edition of the WALL STREET JOURNAL:

> "The Maryland commissioner scaled down the rate increase sought by the Blue Cross after he had received the results of a survey of *222* doctors interviewed by Opinion Research Corporation of Princeton. More than three fourths of the doctors believed 'Hospital facilities sometimes are used in an unnecessary or uneconomical manner.' About 80 per cent said they had patients who had requested hospitalization when it wasn't necessary, in most cases to take advantage of insurance. And 11 per cent of the doctors admitted that 'One fifth or more of their own hospitalized patients are admitted for diagnostic procedures that could be performed in a doctor's office or under hospital out-patient service.' About one third of the doctors said that unnecessary prolonged hospital stays are 'Frequent.'
>
> "Though Mr. Sears was critical of some of the methodology of the survey, he commented, 'Nevertheless . . . I felt that there emerged a picture of a significant amount of unnecessary hospital use by a sufficiently large segment of the population and countenanced by a sufficiently large proportion of physicians to warrant immediate action on my part.'
>
> " 'Doctors aren't policemen for the insurance companies,' snaps a Seattle doctor. 'I don't send patients into the hospital for a rest cure. But if a patient, who is my customer, wants some kind of optional treatment that comes under the payment plan, it's okay with me. This is a competitive business and if I object, he goes to the doctor across the street.'
>
> "A gray-haired Detroit doctor bristles when the question is put to him: 'Do you ever hospitalize a Blue Cross covered patient who might just as well be home in bed?'
>
> " 'You're darn right, I do,' he says. 'And it's not because the patient asks me to, either. I put him in the hospital for my own welfare. I could spend all morning seeing just four or five patients if I have to drive all over town to visit them. But I can see maybe 20 in a morning if they're all in the hospital.' "

I have come at your invitation as the insurance commissioner of a neighboring state to report to you on one adjudication of a Blue Shield plan and to tell you some of the thoughts that impressed me before, during, and after these hearings. The doctors who have sponsored your Physicians Service, the Blue Shield of Rhode Island, just as the hospital people and other public-minded citizens who sponsored your Blue Cross, have done an amazingly successful job. The Blue Shield has already paid upwards of $50 million and the Blue Cross in excess of $110 million for medical and hospital care for many who would have found such service burdensome to the point where they might not have received care when needed.

I have also come to open my mind to you with respect to the need for greater collaboration as between the agencies of government which I represent and the providers of health service which you as doctors and hospitals represent. I strongly believe in the voluntary hospital system and private medicine.

I suggest to you that we in America have a chance of preserving our private system of medical care. It is no more than a chance — but it is worth the effort and the price which must be paid. The price is self-regulation by doctors of the abuses of medical benefits. I need not underline this, it is the matter uppermost in all our minds. I respectfully suggest to you that unless we earnestly strive to overcome such abuse the costs of health insurance will continue to mount. We could be paying a much higher price than I am now suggesting if a government program is undertaken. If you, as doctors, do not heed the sign posts now clearly visible, the profession of medicine as we have known it, is lost. This time is short. There is much to do in the important work of making our voluntary system prevail.

SOME PRACTICAL CHALLENGES TO MODERN MEDICINE

concluded from page 24

to maintain this procedure. I suggest to you that we cannot retain it by shouting slogans or shibboleths. We cannot retain it by labeling everything that we dislike as socialized medicine.

We must analyze each and every proposal which is made upon its own merits. We must not resort to thoughtless labels. Labels are the most dangerous things that were ever invented, except perhaps for the purpose of distinguishing one type of medicine from another. I don't want to draw ridiculous parallels, but I must point out to you as forcefully as I am able to, that by labels, by resorting to shibboleths, we may bring about the very end which we seek to resist.

If you were to read the series of steps leading up to the revolution in 1789 of the French people, if you were to see each and every opportunity which was thrown away not only by Louis XVI, but the general governing class, it would make one almost weep at the opportunities which were given for orderly change. If one would read the RISE AND FALL OF THE THIRD REICH, one could not help but be struck at all the opportunities which were thrown away to resolve the very real problem which faced the German nation. But I submit to you that absolutely by default, by a complete unwillingness on the part of the responsible elements of that nation, were these solutions left to a megalomaniac.

And I suggest to the members of the medical profession, and to those who are engaged in related activities in the Blue Shield Plans, that if these problems are not met with imagination, with thought, with vigor, solutions will be drawn for you — in some instances by those least qualified to make them. The problem must not be left to a default determination.

This means, in general terms, that the alternatives are reasonably clear. What is the alternative to government-sponsored medical prepayment plan? There's only one alternative — the private prepayment plan. We certainly don't expect, nor would any of you want, to turn back the clock to the point where everybody paid his own medical bills, his own hospital bills, and the devil takes the hindmost. We realize that that can happen. Nobody would want it, least of all the members of the medical profession.

But, these private prepayment plans, such as Blue Shield, the only alternative to government intervention and indeed I won't disagree with Doctor Dawe's eventual government control, is that these plans must work. They must not only exist, they must meet, reasonably and satisfactorily, the major economic challenges which are presented to them. This means that they must take care of the bulk of the costs of major illnesses which may without warning strike the home of any of us.

This means that due regard must be given to the special problem of the aged. Again, harking back to what I said at the outset, the great strides in medical competence have so eliminated the epidemic curse that we now have the problem of the degenerative ailment. The degenerative ailment that may take days, weeks, months, years to run its final course.

It is a special problem. And I understand, in some instances, it has been found actuarily unprofitable. This problem must be met. If the King-Anderson bill does not pass this year, or next year, it will pass the third year. And as one who has had some legislative experience, I am so convinced of that, that I would not hold out any reasonable hope of its being wrong — unless the problem is met and solved.

I'm not going to suggest, as the commissioners may do, specific ways in which these problems ought to be solved, because that requires special knowledge. It requires a special knowledge of those of you who have had experience either in the practice of medicine or in the actual dollars and cents administration of a prepayment plan. It would be presumptuous and worthless for me to suggest detailed methods of meeting these problems. But I do suggest that these problems should be met and solved with the active leadership of the members of the medical profession, for you are best able to solve them. It concerns you. If you do not solve them, if you do not make the private prepayment plans of Blue Shield and Blue Cross work, then I assure you that the problems will be solved by those who know much less about them than do you. And in this endeavor, I wish you all of God's help, and all of the public understanding that you can get.

WHAT IT'S LIKE TO PRACTICE UNDER SOCIALIZED MEDICINE*

EDWIN L. DAWE, M.D.

The Author. *Edwin L. Dawe, M.D., of Danbury, Connecticut. Formerly a practitioner under the British Health Service. Now in private psychiatric practice in Danbury, Connecticut.*

I AM A FUGITIVE from socialized medicine. I worked in the British National Health Service, as a G.P. in London 1953-54. I soon discovered that I was no longer a free professional, practicing the art of medicine according to what I believed were the best interests of my patient, but a serf drearily laboring at mass-production medicine according to the often arbitrary whims of an army of bureaucrats multiplying like rabbits in accordance with Parkinson's Law.

I left Britain because of this bureaucratic interference with my practice of medicine and the inevitable lowered standards this entailed, to say nothing of the lowering of the patient's and government's regard for the doctor because of his reduced status. This attitude of disdain for the British health care programs and the doctors who serve under it became widespread soon after the National Health Service was established in Great Britain in 1948.

It is only one — and perhaps the least important — of the potential dangers America faces if a system of nationalized medicine is adopted in this country. The King-Anderson bill, proposed by the administration, is the thin edge of the wedge that might very well bring deteriorating medical standards and medical care in the United States.

As an intern in a London hospital and later in general practice there, I witnessed the unbelievable waste, interference, and bureaucratic regimentation that have accompanied Britain's unwieldy social experiment. I paid government-imposed "fines" for prescribing the best medicine for my patients. I spent anxious hours in search of hospital space for the critically ill. I saw hospital grants frivolously spent on television sets and new carpeting. Practice under the National Health Service soon became intolerable for me, as it has for thousands of British and European doctors who have left their countries to practice in America. I, too, chose freedom and came to the United States to practice under what I firmly believe is the best existing medical system in the world today.

Those who favor enactment of new federal medical care in the U.S. today are making the same wishful promises and tranquilizing assurances that were heard in England thirteen years ago. Americans should heed the lesson taught in England, and guard well the high medical standards and freedoms they now possess.

Abraham Ribicoff, secretary of Health, Education and Welfare, who would administer the proposed law, has been widely quoted as saying that the legislation would not authorize government supervision or control over the practice of medicine, the manner in which medical services are provided, or the selection or compensation of those offering the health care services. However, the bill itself states that hospitals, nursing facilities, and home care agencies must meet such conditions of participation as the secretary of Health, Education and Welfare requires.

The Health secretary says that doctors would not be included in the program. However, the bill specifically includes pathologists, radiologists, physiatrists and anesthesiologists working in hospitals or serving the hospital's outpatient clinics. The bill also would include interns and residents in teaching hospitals. It is naïve to suppose that once this legislation became law it would not be extended gradually to cover all medical practice and health care services for the entire U.S. population. It is equally naïve to suppose that government financing will be provided without government control and ultimate government operation of medical services. The government would be irresponsible if it spent public funds without adequate controls and supervision.

Innocent-sounding provisions of the medical care measure can prove to be far different in practice. I saw similar provisions as they were applied under Britain's National Health Service. For example, the pending medical care legislation limits the drugs and biologicals that will be provided for patients to those included in the *U.S. Pharmacopoeia, National Formulary*, or *New and Non-official Remedies*. In Britain the amount and kind of drugs were also restricted for the general practitioner. Only doctors

*Presented at the New England Blue Shield Professional Relations Seminar held at the Colony Motor Inn, Cranston, Rhode Island, September 22, 1961.

on the staffs of hospitals initially could prescribe new drugs not listed in the *British Pharmacopoeia* or *National Formulary*. Government-licensed drug houses supplied medicines, which the general practitioners were supposed to prescribe by their generic name. Nearly every week, a number of doctors would be fined because they prescribed a drug which in their best judgment was needed by a patient but which was not on the government's official list. Once I discovered that Luminal, a brand name for phenobarbital, which was being produced in large quantities by a private firm, was actually less expensive to obtain than the phenobarbital being made in the government's drug houses.

The restrictions on a physician's judgment to prescribe the best medicine for his patient fell particularly heavily on the younger doctor. For instance, the new man in the field might prescribe a new and expensive drug for arthritis, whereas the older physician might order aspirin. Since the government levied a charge on doctors whose prescriptions exceeded a certain percentage of the average cost for the particular area in which they practiced, the physician who prescribed the more expensive medicines suffered financially. It became natural for a doctor to hesitate to prescribe certain drugs when he knew it would cost him money. It was difficult enough to get by on the restrictive compensation the government allowed.

A physician in general practice was paid a fixed fee per patient per year no matter how frequently he saw the patient. To earn a living of about $4,000 a year he might have had to see approximately 100 patients a day. Medical specialists were attached to hospitals and paid a salary by the government.

Such specialist positions are limited in number by the government; so many a budding specialist is faced either to drudge in relatively low-paid hospital staff posts for years waiting for "dead men's shoes," or else abandon specialization and go into general practice.

Since medical care theoretically was available to everyone at any time, we were literally swamped with patients, many of them with trivial complaints or with no ailment at all. Free service naturally leads to over-utilization. Patients and proper medical care suffer. With the best will and intentions we could not give all the time we should have to our patients. The general practitioner tended to send any cases where diagnosis was difficult or time-consuming to outpatient departments of the hospitals. Less and less minor surgery was done in the doctor's office, since there was no time.

Besides the heavy patient load, the time spent on government paper work was fantastically high. If a man was too ill to work, he had to have a certificate filled out by his physician. For each week he was not on the job, a certificate was necessary, and another certificate had to be completed when he returned to work. Form-filling and correspondence with the government became one of the physician's major functions. He was reduced to the role of part-time clerk.

The lack of time to care for patients meant more of them had to be shunted off to hospitals. Doctors tended to lose touch with their patients when this happened as practically no general practitioners are on hospital staffs. The doctor could visit his patient in the hospital, but he got the uncomfortable feeling that he was in the way, because he had no responsibility for the patient then. The hospital staff was in authority. When the patient was released, his doctor got a brief letter from the hospital saying what had been done, but this break in medical care continuity is hardly the best kind of treatment for the patient. Rarely, too, did the patient have any choice over who would treat him in the hospital.

The people who support the medical care bill before Congress say that it provides free choice of either hospital or doctor. Under the National Health Service, patients not only had no choice of hospitals, they were fortunate to get accommodations at all in the jam-packed institutions. One of the physician's bigger dilemmas often was how to get an urgently ill patient into one of the overcrowded hospitals right away. More than once I spent hours on the phone trying to get hospital care for such people. A central phone service finally was established which relieved this problem to some extent. But private or semi-private rooms were almost unheard of. In some hospitals the crowded wards even had beds down the middle aisles. Unless surgery was of emergency nature, up to a two-year wait was customary. I had several child patients with chronic tonsillitis who were on the waiting list for operations for a whole year.

A major reason why the hospitals were so overcrowded was the heavy load of elderly patients, the very age group that the health care measure now before Congress would cover. Since hospitalization was free, many of the aged in Britain were shuttled off to the hospitals rather than being cared for at home by their families.

I appreciate that the aim of the aged health care legislation is to help a group of citizens who frequently incur heavy medical expenses. However, as a psychiatrist, I am convinced that the elderly person should not be encouraged in dependency. He should not be made to feel that he is a pitied ward of the state, a worn-out object of charity. Let us not destroy the self-reliant spirit. The older patient must have an incentive to keep living, to continue to be useful. To encourage all the aged to give up their independence and become debit members of society, to receive doles regardless of need,

concluded on page 55

USE, BUT DO NOT ABUSE*

PASCAL F. LUCCHESI, M.D.

The Author, *Pascal F. Lucchesi, M.D., of Philadelphia, Pennsylvania, Executive Vice-President and Medical Director, Albert Einstein Medical Center, Philadelphia.*

RHODE ISLAND, although physically the smallest state in the Union, is in many respects, the biggest state. For example, Rhode Island has the highest per cent of its population enrolled in Blue Cross of any state in the nation. Of the 853,000 people who live in your state, 645,000 have Blue Cross. Over 75 per cent of the population have accepted Blue Cross as their way of prepaying the cost of hospital care.

This is not a small achievement for the Rhode Island Blue Cross Plan and the people of this state. The people benefit by being assured that modern hospital care can be made available to them at little or no cost at time of illness. Hospitals benefit by being assured of a dependent, steady source of income.

Blue Cross membership in the United States is at an all-time high — over 56 million Americans have Blue Cross. Payments to hospitals are higher than ever before—almost one and two thirds billion dollars were paid last year to our hospitals. Yet Blue Cross faces serious problems which deserve the thoughtful attention of hospitals, physicians, government and the public. One such problem is assurance that Blue Cross benefits are being used wisely. This is a vast subject, which I do not intend to cover in any great detail today. But perhaps I will be successful in pointing out the significance of this subject and stimulating thinking with respect to developing a wise approach to utilizing hospital services and Blue Cross benefits.

In recent years, the subject of alleged "abuses" of Blue Cross benefits has been bandied about not infrequently. It has been extremely rare, however, that any outright deception or collusion has been uncovered regarding the use of Blue Cross benefits. This type of "abuse" is so infrequent that it does not deserve our attention, and is not the problem which doctors, hospitals, and subscribers need to consider regarding the existing pattern of Blue Cross utilization.

*Presented at the New England Blue Shield Professional Relations Seminar held at the Colony Motor Inn, Cranston, Rhode Island, September 23, 1961.

The problem is more subtle. Repeated studies show that Blue Cross subscribers stay in the hospital just a little longer than non-Blue Cross subscribers. This seemingly harmless difference can, in fact, spell the difference between a competitively strong Blue Cross movement in America, or one fraught with endless merchandising difficulties. May I remind you that Blue Cross is the only mass nonprofit prepayment Plan in America — that it provides almost all of the lifetime "service benefit" coverage which exists today — and that protecting the American people with this type of coverage is the most effective way there is for guaranteeing the continued development of our voluntary hospital system. The success of voluntary hospitals and private medicine is tied with the success of Blue Cross; and the success of Blue Cross has much to do with its benefits being used in a most judicious manner.

Of the repeated studies which point out that Blue Cross subscribers have a higher utilization than non-Blue Cross subscribers, the most recent, and the most provocative, is the Kellogg Foundation Study conducted by the University of Michigan. This Study points out that average length of stay for Blue Cross subscribers in Michigan is 7.4 days. The figure for people with private voluntary insurance is 6.3 days. The cost of an extra day per admission added to the extra cost of Blue Cross' social approach of providing lifetime service benefits, could be the straw that will break the camel's back. Blue Cross cannot afford a higher utilization than commercial insurance, and there appears to be no medically justifiable reasons why it should have a higher utilization than other insurance.

Let me bring this story a little closer to home — your home — the state of Rhode Island. The American Hospital Association reports in its GUIDE ISSUE for August, 1961, that last year average length of stay in short-term voluntary hospitals in Rhode Island was 8.7 days. Hospitals in your state have the second longest length of stay of those in any state in the nation. Hospitals in New York and in my own state, Pennsylvania, have the dubious honor of tying for first place, with an average length of stay of 8.8 days.

As we look at length of stay around the nation, and as we look at the per cent of population en-

rolled in Blue Cross, we see a curious relationship between the two: As the per cent of population with Blue Cross goes up, length of stay becomes longer. As the per cent of population with Blue Cross goes down, length of stay becomes shorter.

Consider these figures:

	Per Cent of Population Enrolled in Blue Cross	Average Length of Stay (Short-term Voluntary Hospitals)
Middle Atlantic	52	8.6 days
New England	51	7.8
East North Central	38	7.7
West North Central	27	7.7
East South Central	24	6.6
South Atlantic	22	7.0
Mountain	22	6.3
West South Central	14	6.1
Pacific	12	5.9

Of course, there are many factors which affect regional variations in length of stay. But it would appear that the per cent of population enrolled in Blue Cross is one such factor. Could it be that we doctors have been too liberal in deciding how long Blue Cross patients need to remain in the hospital? Has our judgment, which is supposed to be based solely on medical considerations, been influenced by the fact that Blue Cross subscribers have little, if anything, to pay at time of illness? Do patients in Rhode Island — where Blue Cross enrollment is highest — really need to remain in the hospital an average of 8.7 days, while patients in California — where Blue Cross enrollment is quite low — stay an average of only 6.1 days?

I am not going to answer these questions for you. But consider the competitive implications for Blue Cross if its length of stay persists in being longer than that for commercial insurance Plans. Consider the importance of Blue Cross — with its lifetime service benefit protection — to the welfare of our voluntary hospital system.

As we come to recognize the vast regional differences in the pattern of utilization of hospital services which exist in this country, we realize that no region need assume that its pattern of utilization is unchangeable. I would offer, as the first step toward developing a wiser approach to utilizing hospital services and Blue Cross benefits, to determine in detail how utilization here compares with that in other sections of the country. I have given you a few figures, and I shall give you just a few more — in case one or two of you are still complacent with present conditions!

With respect to short-term voluntary hospitals, your average length of stay (8.7 days) exceeds the national average (7.4 days) by 18 per cent; your cost per day ($37.83) exceeds the national average ($33.23) by 14 per cent; and your cost per admission ($329.12) exceeds the national average ($245.90) by 34 per cent.

Every Medical Staff Needs a Utilization Committee

There are many measures which hospitals, physicians and Blue Cross can take which would serve to shorten length of stay. The most successful technique yet devised by the medical profession for shortening length of stay and assuring proper use of hospital services and Blue Cross benefits is to establish a utilization committee as an integral part of each hospital medical staff. Such a committee sees to it that: (1) Hospital service is rendered on an out-patient, rather than in-patient, basis whenever medically feasible. (2) In-patient admissions result solely from medical necessity — not as a "convenience" to patients or doctors — not to fill empty hospital beds. (3) Diagnostic and therapeutic services are related to diagnosis — not prescribed because the patient requested such services or because insurance will pay the cost. (4) Hospital services are available promptly at all times, so that patients admitted on Fridays, Saturdays, and Sundays receive on these days the services they ought to receive on the first days of their admissions — and not have to wait until Monday or Tuesday. (5) Patients are discharged as soon as medically feasible — not at the "convenience" of the patient, his family or the physician in charge.

There are a number of measures which Blue Cross can take which help shorten length of stay. The newest, and perhaps the most effective program to shorten length of stays is to offer limited approval on Blue Cross admissions. The Philadelphia Blue Cross Plan will initiate this fall a limited approval program which will work this way: (1) Blue Cross will approve admissions for an initial allowance of 14 days (assuming a subscriber is entitled to at least this number of days). (2) If a subscriber remains in the hospital for 12 days, the hospital would then inquire from the physician in charge if the patient is expected to need more than the initial allowance of days and, if so, how many additional days would be needed? (3) If the patient is expected to need additional days, the hospital would obtain from Blue Cross an additional allowance of days.

Various types of limited approval programs have been used quite successfully by a number of Blue

concluded on next page

Cross Plans, because they serve to remind doctors of the importance of discharging patients as promptly as medically feasible.

What Can Hospitals Do to Shorten Length of Stay?

The ways hospitals are operated can strongly influence length of stay. A hospital administrator who is dedicated to developing the shortest possible length of stay for his patients should ask himself these questions:

1. Is pre-admission laboratory work being used to full advantage?
2. What arrangements are there for performing routine diagnostic tests upon admission of patients?
3. How, when, and by whom is the doctor notified that his patient has been admitted?
4. How much time elapses between admission of patients to the nursing unit and the (1) doctor's first visit, and (2) writing of orders?
5. How are requisitions transmitted to the various departments?
6. How are the various professional service departments staffed during the day and by day of week? What arrangements exist for routine work on evenings and on weekends?
7. What are the arrangements for transmittal of reports on diagnostic tests to the nursing units? How soon after receipt of reports are they affixed to the patient's chart?
8. How is operating room time assigned?
9. Is admission of cases co-ordinated with the schedule of surgery?
10. If there is no elective surgery on Saturday, to what extent does lack of a six-day schedule affect length of stay?
11. To what extent is surgery postponed because reports have not been received from other services? How much time is lost in rescheduling?
12. Is there a 24-hour notice of discharge system? Who notifies the family when a patient is to be discharged?

The right answers to these questions can go a long way toward producing a smooth flow of patients through the hospital. This can contribute quite substantially to assuring the shortest possible length of stay.

The American approach of meeting the health needs of the nation through voluntary efforts will always be challenged to some extent. This is desirable. It keeps us on our toes. It is likely, though, that as the cost of hospital care continues to rise, the public spotlight will shine more brightly on our voluntary health system. We had better be certain that our house is in order. I predict that as per diem costs rise, we will discover that, what we thought were impossible with respect to lowering utilization, will suddenly become possible. If we are smart, we will begin the job of developing a whole new approach to utilizing hospital services and Blue Cross benefits. The need for Rhode Island to change the existing pattern of utilization is almost as great as the need for us Pennsylvanians to do the same thing. And this is saying a lot!

E. P. ANTHONY, INC.
Druggists
WILBUR E. JOHNSON, Phar. D.
RAYMOND E. JOHNSTON, B.S.
178 ANGELL STREET
PROVIDENCE, R. I.
GAspee 1-2512
Pharmacy License #225

Sans Souci Hotel
OCHO RIOS, JAMAICA, W.I.
A small, modern resort hotel with a magnificent view and a Continental air. It is foreign. Doctors love it. Outstanding cuisine. French Chef. Sea Dining Terraces. All rooms with private balconies, tub-showers, sea views. 2 private beaches. 10 tropical acres. Famous rejuvenating mineral water swimming pool. Entertainment.
See your local travel agent, or write:
Fred Van Benschoten, *Proprietor*
Jean-Pierre Aubry, *Manager*
"JAMAICA AT ITS LOVELIEST"

PATRONIZE JOURNAL ADVERTISERS

REFLECTIONS ON THE KING-ANDERSON BILL (H.R. 4222)*

Part I, The Principle of the Bill

Reverend Stanley Parry, C.S.C., Ph.D.

The Author. *Reverend Stanley Parry, C.S.C., Ph.D., of South Bend, Indiana. Chairman, Department of Political Science, University of Notre Dame, South Bend, Indiana.*

The Care of Dependents

Every decent society has in it institutions and processes to provide for its dependent members. Since, for our purposes, we can define dependency most generally as the condition of receiving inadequate or no current income, we find that every society has arrangements for the young, the aged and the indigent. For although the differences among these three groups are profound, they have this in common that they receive no income from current work. Since they do not, their physical existence requires that they receive income without working — a situation fraught with temptation for "our tricky human nature." It should be no surprise to those who understand human nature to know that such provisions have always been, and one can confidently predict that they always will be, the source of abuse.

Established Principles for Public Care

However, out of centuries of experience in this area, there gradually emerged a set of basic principles concerning the manner in which public authority should deal with this complex problem. Those principles may be summarized as follows:

1. Public authority intervenes in the marginal case where the relatives of the indigent person cannot provide the needed unearned income.
2. Public authority does not intervene except upon proof of helpless need.
3. Consequently public authority intervenes *post factum*; the need must materialize and be known before it is dealt with.
4. Helpless need is dealt with on a person by person basis.
5. Finally, the public authority deals with the need on the local level.

Let us summarize these principles as constituting the principle of the marginal local relief of proven indigence.

Stated thus baldly the approach seems to the modern mind to have a niggardly and small-spirited air about it. But if we examine the foundations on which it rests, we find a statesmanly and prudent estimate of human nature, of society and of the purpose of the state. All relief of indigence has this about it, that it must deal with the human desire to get something for nothing, and to put up with a reduced standard of life if that reduced standard can be gotten for nothing. This is the source of most of the abuses connected with public aid. Beyond this view of human nature, there lies a view of society and of the relation of political authority to it. Basically, the traditional approach sees society as an on-going socio-economic complex having in it an order which is sustained by self-adjusting mechanisms, by agreements and understandings, by self-realizing expectations and by many types of non-political authority ranging from religious leadership through corporations and unions to voluntary self-help co-operatives. The expectation is that within this vast complex everyone will find his rightful niche and just reward. The state intervenes to pre-

continued on next page

One of the most controversial legislative proposals before the Congress is the King-Anderson Bill (H.R. 4222), a measure to finance certain limited medical care for the aged through Social Security.

Reverend Stanley Parry, C.S.C., chairman of the Department of Political Science at the University of Notre Dame, presented one of the most thought-provoking reports on the legislation to the Congressional House Ways and Means Committee at the hearings on the bill last summer. A graduate of Notre Dame in 1941, Father Parry received his Master's degree from Georgetown University, and his Doctorate from Yale University, and he has taught at Notre Dame since 1950.

Because this is an outstanding review of the legislation which will be renewed by the Congress this year, it is being published in the Rhode Island Medical Journal in two parts. This issue carries Part I, *The Principle of the Bill.* In February we will publish Part II *H.R. 4222 As an Insurance Plan* and Father Parry's general conclusions.

The Editors

*Testimony presented to the U.S. House Ways and Means Committee, July 28, 1961, on the proposed King-Anderson Bill (H.R. 4222), a measure to finance certain limited medical care for the aged through Social Security.

serve justice, to remove artificial barriers to this adjustment process. And it intervenes when the system does not work out for some who consequently experience helpless need. Moreover, in the particular case, it intervenes only when it has been ascertained that this helpless need cannot be satisfied by some other part of the social system. This view assumes that the unfortunate case is not the typical one. It postulates that there is no permanently enduring cause of indigence that predictably affects definable groups of people who therefore can be aided before the fact. It postulates, that is to say, indigence as an unpredictable *mis*fortune which cannot be handled *a priori*. The law consequently tends to define *conditions* that warrant relief, not *classes* of people who *ipso facto* will receive it. This view, finally, is rooted in a clear perception of the limited purpose of state action. For voluntary groups, the relief of indigence is an act of Christian charity. And this motive tends, in the popular mind, to be identified as the motive for public aid. But the state deals with justice and order, not charity. Its intervention into the processes of society can be defended in the case of indigence only on the grounds that it must prevent the crimes, the violence, the deep disaffection that result from the presence of hunger and unprotected youth. On the most general level, the state succors the indigent to remove from society the violence implicit in the crass neglect of individuals suffering helpless need. The state, hitherto, in our democratic tradition, has never conceived of itself as the guarantor of the good life or the comfortable life. This was confidently held to be something earned by the individual in a society where it could be earned, provided only that the state did not impose artificial barriers to achievement.

The New Principles of H.R. 4222

Of the three categories of persons who do not receive income from current work, the aged have a special characteristic: unlike the young and the indigent, they are not dependent by definition. Youth is a cause of dependency; indigence denotes a fact of dependency; but old age of itself signifies nothing concerning the condition of dependency. In a simple agricultural society, old age is and was a cause of dependency: when one was no longer able to work he automatically became dependent on others for income for the rest of his life. This is a clear case of what I would call a permanent and perduring cause of dependency or indigence. But an industrial society, through the mechanism of savings, whether insurance or investment, offers a method whereby the aged can be independent in the absence of currently earned income. Consequently, whether or not an elderly person is dependent is a question of particular fact in our society. Moreover, the affluence of the society which makes it possible for a working man to save, makes it more likely that in the particular case of aged indigence, relatives or voluntary groups can relieve the need that was not or could not have been handled by prudent foresight. The marginal cases remaining can be handled by the local authorities under the principle of indigence.

A close examination of the findings of H.R. 4222 reveals a new orientation of fact and policy. The fact is found that the incidence of medical indigence among the aged is sufficiently large to justify the identification of aged as a medically indigent *class*. The cause of the indigence is attributed to 1) the "heavy costs" of medical care and 2) the inability of the aged to protect themselves by insurance from these costs. The existing cure for such indigence is considered unsatisfactory because it puts an undue burden on general revenues and accentuates the difficulties of hospitals and welfare agencies (local presumably). In its place therefore the bill proposes to relieve this general indigence by a system of social insurance which, by implication, will avoid the defects of the existing cures. The implication is that since the process to be set up is that of insurance rather than welfare relief, the new method will not burden the general revenues nor will it accentuate the difficulties of hospitals and welfare agencies. The bill, in short, proposes the most profound changes in the approach to the question of the relief of medical indigence. First, it abandons the principle of marginal relief of indigence. Second, it establishes an *a priori* category of indigence. Third, it abandons the principle of local intervention. Finally, it depends essentially on the assertion that "social insurance" is essentially different from welfare relief as a method of providing the needy aged with medical aid. In short, in place of the local marginal relief of proven indigence, H.R. 4222 introduces the principle of federal preventive intervention for the relief of a general condition of indigence.

The mere abandonment of ancient principles, however, cannot of itself constitute proof of error or imprudence. The vast changes in modern industrial society would set up the assumption that some ancient principles will have to be adjusted and others even abandoned. Therefore, the issues the present bill raises are whether it appears in response to such a change in the condition of the aged that new principles of intervention are needed, and whether the processes of H.R. 4222 are really different from those now existing.

The Emergence of the Preventive Intervention Principle

The emergence of new factors in industrial society has required among other things adjustment in the application of the principles for public relief of indigence. The characteristic cases are those in

which permanent, predictable and continuously operating causes of need make the *post factum* relief of need unreasonable. But it should be noted that in the typical adjustment, the fundamental principles for the relief of indigence have been treated reverently.

To illustrate the nature of such adjustment, let us consider the case of public education. With regard to education, two things became evident in the course of time. One was that an industrial society cannot operate unless its people are literate. The other was that in an industrial society the family could by itself solve the problem of educating youth. What arose in fact was a case of need among youth which could not be adequately relieved by relatives or voluntary organizations. Moreover, there existed also a need on the part of society that literacy be widespread. Finally, illiteracy is a phenomenon which cannot be handled on the basis of *post factum* intervention. The policy followed to solve this problem is a clear case of preventive intervention. Public authority intervenes to prevent the appearance of illiteracy. Note, however, the care with which intervention occurred. First, the principle of local control was followed: a system of school boards gradually covered the land. Secondly, the policy adopted preserved the concept of marginal intervention. The substantive evil was forbidden by the provision of compulsory education. But there the compulsion ceased. One was not compelled to attend any particular school. The public school system was built only for those who did not or could not attend private schools. The fact that most children go to public schools should not obscure the marginal legal character of the system. It is still legally possible for all schools to be private, but not for all to be public. In our policy on schooling, we have a beautiful example of the adjustment of ancient principles of wisdom to the conditions and needs of modern society.

A much more complex case of adjustment, one currently facing the country, is that of industrial unemployment. If we restrict our attention solely and precisely to technological unemployment we can find a new type of indigence flowing from permanent and continuously operating causes. Technological unemployment is the price of industrial progress. Consequently the principle of preventive intervention may not be applied. In the nature of the case this type of unemployment must be solved *post factum*. But, on the other hand, technological unemployment cannot equitably be treated on the principle of marginal indigence. To do so would make the few whose jobs disappear bear the cost of progress for the many. It is recognized by most that this type of unemployment should be considered a social cost and be met by society. Society is now debating how this can be done without creating more problems than are settled.

In these two cases we have new situations in which the marginal relief of proven indigence is inapplicable. For education, the *post factum* element was inadequate. For technological unemployment, the indigence element is unfair. For the one, the principle of preventive intervention was relevant; for the other, it was not. For youth, a class of needy could be defined *a priori*. For the technologically unemployed, the need has to be identified individually and *post factum*. It would seem from this that in any change of policy regarding indigence, three major aspects of the situation need investigation:

1. Is a change necessary as a matter of fact: does a new need exist?
2. Is this need a consequence of permanently operating causes?
3. If there is a new need, can it be met by adjustment of principle?
4. If it cannot, what are the consequences of introducing the principle of preventive intervention?

On every one of these counts H.R. 4222 fails to justify itself. It can point to no emerging new need among the aged. It can identify no permanent and continuously operating causes of medical indigence among the aged as a group. And it betrays a confused insight into the mode of operation and the consequences of the process it would set up. One must remember the precise question at issue here. We are not asking whether many aged are medically indigent. We are asking whether the condition of the aged in this regard has changed so radically as to require a totally new solution to their problem. The bill roots its proposals in the finding that such a change has in fact occurred. It identifies the elements in the change as financial inadequacy in the aged themselves, the growing costs of medicine and the increased difficulties of local welfare authorities. Let us examine each factor in turn.

Behind the term "most" in the opening lines of the bill there lie two considerations: 1) the position of the bill itself that "most" cannot protect themselves with medical insurance, 2) the position in the public forum that most are generally indigent. With regard to the first position, there are few who would quarrel with the statement. But in the application of this finding, we find that only "many" of them (the aged) are forced to apply for medical aid. Consequently this places burdens on local hospitals and relief agencies. With regard to the burden there is no doubt that the medical relief of the aged sick is a burden. The findings of the bill simply report the reasons why the states of the Union provide medical relief for the aged. The bill achieves its impact by a series of confusions: 1) the glide from "most" to "many," 2) the implication that the burdens experienced have somehow become mark-

concluded on next page

edly greater, 3) the indiscriminate mixing of private and public relief activities. The issue here is focused on the policy to be followed for those cases which fall within the domain of public relief, i.e., relief met through taxation. This confusion is supported in the public debate about the bill by a strategic statistic: three fifths of all over 65 have less than $1,000 cash income a year. This statistic, along with some concerning the increase in the cost of medical treatment, becomes the basis for holding 1) the existing facilities for relief are inadequate, 2) the Federal Government must take over the burden, 3) it must do this on a general basis, i.e., must treat the aged as a group as indigent.

The statistic that three fifths of all those over 65 receive less than $1,000 cash income per year is indeed an amazing one. It would seem from it that the aged in America are a poverty stricken group. On the face of it, this is a misleading statistic. I do not say it is a false one. But obviously the aged as a group are not in the sorry financial condition this statistic suggests. There are not nine million impoverished aged in America. There are only 2.5 million of them on the public assistance rolls in America. Moreover, we learn from the report of the Department of Health, Education and Welfare that the median total income of retired Social Security beneficiaries is $183.00 per month. We learn also that the average retired couple has a median net worth of $9,620, that 75 per cent of OASDI beneficiaries own their own homes and 87 per cent of these homes are mortgage free. Remember, there are only 15.6 million aged in America. Of these, 1.5 million receive pensions from corporations, 10.8 million receive some form of government compensation, one million receive privately purchased annuities, 3.7 million are recipients of currently earned income. If we subtract the 2.5 million receiving welfare, and consider the overlap indicated in the figures above, signifying that many receive income from more than one source, it is difficult to perceive the shape of poverty here. To draw the picture in dollar terms, the aggregate income of persons over 65 is between 25 and 30 billion dollars a year. Of this $6.7 billion derives from OASDI assistance, $1.7 billion from employment, $7 billion from interest, dividends, rent, etc. Far from showing the existence of permanent causes of indigence in the aged, the statistics suggest a hopeful withering of the causes of the indigence that does exist.

How then, can we account for this poverty statistic of less than $1,000 per year? Is it a false statistic? Not at all. One can derive it from the facts, if the facts are counted in a certain way. Suppose the aged enjoyed a single uniform condition in America: all are married couples, the husband has an income of $10,000 a year, but the wife has no formal income of her own at all. One statistical result would be that one half the aged in America have no income at all. To get it one need count only individuals. This result could conceivably be relevant to some sort of problem in America. But it certainly is irrelevant to the problem of medical aid for the aged. For the issue here is how much personal income is available for the use of the aged in America. And one could hardly hold that the income of a husband was not available to his wife. The relevant way of counting in this case is to count the family unit income. If we use the method of HEW we can find an even more poverty stricken group in America: the young, those under 14, of whom I would guess nine tenths receive less than $500 cash income per annum (and I am not at all sure that HEW will not presently discover this deplorable fact and do something about it).

A second defect in the poverty statistic lies in its restriction to cash income. A different picture is gotten if the liquid assets of the aged are included in the calculation. And this picture is lightened more when one projects into the future the past gradual improvement of the aged with regard to liquid assets. Moreover, the cash income of the aged, dollar for dollar, has a higher value than that of the younger groups. For the general expenses of the aged are much lower. A dollar goes further when one does not have to raise children, pay for a home and carry insurance to protect the family from the death of the income earner. Even the clothing and recreation costs of the aged are lower.

The point of all this argument about statistics is that the condition of the aged *as a group* is by no means desperate. On the contrary it looks good, and all the trends are favorable to future improvement. The poverty approach is not tenable. If we consider the evidence in support of the finding of fact in the bill, we find no such proof and no such identification. Indeed, the evidence in favor of a change of policy is so meager as to compel the conclusion that the desire to change is rooted in a sheer option, in a stark will to handle the matter this new way instead of the old way. While recognizing that medical indigence among the aged is higher than among other age groups, absolutely no case can be made for the claim that the incidence of need is widespread enough to warrant handling the relief of such need on an *a priori* group basis. The increase in the absolute number of the aged and the steady extension of life expectancy constitutes massive evidence for the opinion that the aged, whether from self-help, relatives or local public aid, are enjoying adequate medical care. The marginal relief of known indigence is still the better policy.

TO BE CONCLUDED IN THE FEBRUARY ISSUE

Editorials

"THE FLABBY AMERICAN"

THAT WELL-KNOWN SOBRIQUET, "The *Ugly* American," has been earned by those of our countrymen who have flaunted the supposed superiority of their homeland in the face of their hosts overseas. Of this we are ashamed. To our shame also it can be said that many of the same individuals, and unfortunately a multitude of others, have also earned the almost equally opprobrious title, "The *Flabby* American." How can a person who takes the elevator to go up two flights to his office, who gets out his automobile to travel three blocks, and who cannot even carry his own golf clubs pretend to be an example of vigorous health? Throughout history national over-prosperity has been the forerunner of national downfall. Can Americans afford to lose the sturdy physical toughness that has allowed our forebears to build a nation such as ours?

What is the outlook today for the overfed, underexercised "successful" man of the present day? He is well protected against infections generally as a result of public hygiene, modern antibiotics, and other measures, and his outlook for a longer life is definitely better than that of his father and grandfather. He does, however, have the constant threat of early atherosclerosis, particularly of his coronary arteries, with the chance of sudden death, even in his forties, hanging over his head like the sword of Damocles. He can look forward to the probability of spending his later years as a pulmonary cripple from the obstructive emphysema that has resulted from long years of inhaling cigarette smoke, provided of course that he had escaped the development of bronchogenic cancer.

We all know of the general tendency of the adult public to take its exercise vicariously by watching the exploits of professional athletes from an uncomfortable seat at the ball park or more often from the easy chair before the television. We all are familiar with the great yellow rather hideous school buses that deny our children the health-giving experience of the daily walk to school, albeit we must admit that city streets are not the safest places for children to walk. This is but a minor instance of the great damage to the human race that has resulted from the development of the internal combustion engine. Perhaps human legs may, in the course of evolution, atrophy and disappear, they are so little used in the normal process of getting a person from place to place.

What of the cardiac patient, the man, for example, who has survived a myocardial infarction and finds himself relatively fit? In so many instances such a man, who may even be a doctor, is afraid to undertake the normal degree of exertion that is needed to keep his recently recovered myocardium in good condition. We find him avoiding stairs, always riding when he should walk and in every way insuring that his heart muscle will stay in as poor condition as possible. Exercise, as Doctor Raab, Doctor Paul White, and others have clearly pointed out, is definitely beneficial to the damaged heart if kept within the bounds of its ability to respond and to increase its efficiency.

The situation is clear. Normal exercise, moderation in indulgence in three of the many curses of modern so-called civilization, rich food, cigarettes and cocktails, will do a great deal toward improving the health and the achievements of the people of this country and of making sure that in the future the average citizen is no longer "The Flabby American."

MEDICAL TEACHING AND THE MOVIES

THE ADVENT of motion pictures has had an important impact on medical teaching, particularly at the postgraduate level. Just one example of the use of this medium will suffice to demonstrate its profound influence. The conduct of the annual Congress of the American College of Surgeons has been greatly altered first by the introduction of surgical films and more recently by television.

continued on next page

Within the memory of many surgeons still actively engaged in practice, operating room attendance at live operations was the only method during medical conventions of observing well-known surgeons or new procedures. This required arising at an unhealthy hour, long taxi or subway rides, standing six deep in a crowded, stuffy operating room, and usually seeing very little. The comparative convenience and comfort of the modern surgical meeting can hardly be overemphasized. There is, of course, new wide application of the cinema in clinical and research activities.

It is not generally realized that the use of the motion picture for surgical teaching was first proposed in America over fifty years ago by the great Doctor Rudolph Matas of New Orleans, a pioneer in many fields of surgery. He made this proposal in his presidential address before the Southern Surgical and Gynecological Association at Washington, D.C., on December 13, 1911. This scholarly and classical dissertation delivered four years before the opening performance of BIRTH OF A NATION was titled *The Cinematograph as an Aid to Medical Education and Research: A Lecture Illustrated by Moving Pictures of Ultramicroscopic Life in the Blood and Tissues, and of Surgical Operations.*

He stated: "I have . . . sought . . . with no claim to authority or special competence, to direct your attention and enlist your sympathetic interest — as teachers and skilled technicians — in the value and availability of another method of photographic reproduction, which I believe, far surpasses all others in inherent interest, educational value, and in its immense though undeveloped possibilities for the scientific and technical training of the men of our craft." He added: "Who can gainsay the enormous advantage to the medical students of this country if they could have the privilege of witnessing, in their own lecture rooms, the scenes and accomplishments which are enacted by the great masters of American surgery in Rochester, Baltimore, Chicago, Boston, New York, and Philadelphia and other places; to see each and every one of the classical operations of surgery performed by a recognized authority in that particular operation?"

He credited the original concept of surgical films to E. Doyen of Paris, who had pioneered in the techniques fully fifteen years before. It is of great interest that Doyen had actually used color film in some of his prints. Matas illustrated his lecture with actual showings of several microcinematographs, as for example the human blood in motion, the ameboid motion of leucocytes, and agglutination of bacilli in the Widal test, and several of Doyen's surgical recordings which were even then available commercially through a Parisian firm. Active steps were then being taken to provide suitable inexpensive home-type cameras and appropriate film in America.

He concluded with characteristic vision: "The purpose . . . in issuing these new machines and films is to make them especially useful and available for educational work in schools, churches, and all kinds of organizations. By this means we see the time rapidly approaching when the surgical specialist or teacher of surgery may keep a cinematographic record of his own operations and thus establish the basis of a mutually co-operative and interchangeable cinematographic surgical clinic in which all the interested workers can participate."

AVIATION MEDICINE

THE FIELD of Aviation Medicine is one which has not been too thoroughly understood by the average practicing physician, and many misconceptions have been associated with it.

It seems to have had its origin during the period of World War I, when it was realized by specialists in military medicine that many men who were qualified physically for combat duty in the various branches of the military service were not necessarily qualified for pilot duty, and that many aviation accidents took place as a result of defects, either physical or mental, in the pilots themselves rather than deficiencies in the aircraft. Thereupon, rigid physical and mental standards were set up by the military authorities, and all applicants were required to meet these requisites.

The Bureau of Air Commerce was instituted in 1926. Since rigid standards which had been adopted by the military had proven so effective, it was thought that a similar set of requisites should be inaugurated for the civilian pilots. The Bureau of Commerce organized a Medical Section to maintain these requirements.

Physicians examining pilots were then given special training with emphasis on certain defects to be discovered in the various applicants in order to select better candidates for flight training and to eliminate candidates with pertinent physical and mental defects.

The Army School of Aviation Medicine thus came into being, with all physicians assigned to medical duty with aviation units required to be graduates of the School of Aviation Medicine. This same training was later recognized by the Civil Aeronautics Authority and later by the Civil Aeronautics Administration. Physicians chosen by the latter agency were required to have some concept of aviation medicine, and wherever possible a desig-

nated medical examiner with some training in this field and cognizant of special medical responsibilities was chosen.

The present Federal Aviation Agency, through the Bureau of Aviation Medicine, has been adamant in requiring that all its designated medical examiners receive special training during certain periods, at stated intervals, in the various fields of aviation medicine, in order to insure a broad program of safety for public aviation. The examiner's first responsibility is to the traveling public. He must not compromise its safety by disclosing all possible avoidable disabilities that might occur to pilots during flight. His second responsibility lies in the practice of preventive medicine, rather than in serving merely as a watchdog to detect gross physical existent defects in pilots.

At his disposal is the Medical Certification Division of the Federal Aviation Agency, to which he may consult for evaluation of a possible substandard physical finding in the airman.

Clinical examination centers are established in four major cities throughout the United States, where the airmen having questionable qualifications may have their status fully studied and determined. In the event that the problem remains unresolved, the airman may be further examined by one or more consultants in the medical specialties who are under contract to the Bureau of Aviation Medicine.

One of the prime responsibilities of the medical examiners, in addition to the discovery of physical defects and gross mental deficiencies in candidates, is the detection of various "human frailty elements" that may exist in the airman seeking a private pilot's license for the first time. Among these are "cocksureness" with a tendency towards insufficient mental reflection, emotional instability, impulsiveness, irresponsibility, preoccupation, compulsive behavior, chronic alcoholism, anxiety states in a psychoneurotic, a poor sense of judgment, and other such variables that might affect a pilot's performance in flight and endanger flying safety.

The over-all functions of the Bureau of Aviation Medicine, under the Federal Aviation Agency, include a responsibility to promote safety by developing standards and regulations concerning the mental and physical fitness of airmen as well as all others whose health affects safety in flight. These functions are carried out by the various branches of the Bureau: a) The *Research Requirements Division* — which provides a centralized source of information concerning Aviation Medical Research throughout the entire world. b) The *Medical Standards Division* — which issues the appropriate standards and regulations concerning mental and physical fitness. This Division includes the *Accident Studies Branch* which investigates the medical aspects of civil aircraft accidents. c) *The Medical Certification Division* — which supervises a worldwide system of medical examiners, reviews the reports of airman medical examinations, passes judgment on all reports of substandard physical findings in airmen, and offers a readily available facility to which airmen can turn to have their condition evaluated.

José M. Ramos, M.D.
Newport, Rhode Island

Curran & Burton, Inc.

INDUSTRIAL
AND WHOLESALE

COAL **OIL**

17 CUSTOM HOUSE STREET
PROVIDENCE, R. I.
DExter 1-3315

TESTIMANIMAL



No butts about it
— I want more

WARWICK CLUB
GINGER ALE

It sings in the glass



PROFESSIONAL SERVICES INDEX STUDY*

WILLIAM H. HORTON, M.D.

The Author. *William H. Horton, M.D., of New Haven, Connecticut, Executive Director and Director of Medical Services, Connecticut Medical Service, Inc., New Haven, Connecticut.*

IN REPORTING CERTAIN STUDIES to establish a professional services index which had been carried on in Connecticut in 1952, we ventured the opinion that it was "most probable that medical practice would have to produce a professional services index, or its equivalent, within the next few years" as one of the conclusions of the report. While it took considerably longer than a "few years" it is most satisfying that Blue Shield Participating Physicians have done for themselves this job which needed so badly to be done.

Why was it so comparatively easy to secure support for this project in 1961 when so little success had accrued to our previous efforts?

The solid unqualified support which was accorded the project both by the Board of Directors of National Blue Shield as well as the Conference of all Blue Shield Plans in April seems to me the finest testimony that Blue Shield has come of age.

It seemed as though all of the Blue Shield Plans, which have been serving the American people for varying periods of time from one to over 25 years, had simultaneously reached their majority. It seemed as if the uncounted warnings of potential governmental interference in the private practice of medicine and of the competitive difficulties of continued growth of enrollment had finally been heeded. It seemed, in fact, that Blue Shield and its Participating Physicians had at long last come to realize that a boy cannot do a man's job and had lifted themselves by their own bootstraps to attain the stature necessary to meet the challenges ahead.

While the professional services index was not developed using our original formula, it is probably more significant since it deals with practical rather than theoretical considerations. For the benefit of those who are not familiar with the index project, and at the risk of boring those who are, we would like to outline the manner in which it was developed. The impetus to develop the index resulted from a discussion of the inadequacies of the existing Blue Shield National Account Agreement during the Executive Committee meeting held in conjunction with the Clinical Session of the A.M.A. in Washington on November 27, 1960. We volunteered to attempt to find some rational basis for uniformity. This initial phase was entirely experimental and dealt with statistical material of Blue Shield in Connecticut, the National Account Agreement and the fee schedules of the ten largest Blue Shield Plans. Our findings from this work were reported to the Board of Directors on February 4, 1961, and while we were still a long way from achieving our goal, the Board was interested in the approach being used. The appointment of a committee to complete the work was authorized and its members literally represented Blue Shield from coast to coast.

All of you have served on committees over the years and I am sure, like myself, you have often found yourself in complete agreement with that frequently expressed opinion regarding committee work; that is, that a camel may best be defined as being a horse that was put together by a committee. The index committee was remarkable in many ways; most important, however, is that it got its job done. While it is not possible to describe to you in detail how effectively the committee worked, the simple fact that the basic principles for the construction of the entire index were accomplished between the first meeting of the committee on March 15 and its report to the Board of Directors and the Conference of Plans on April 15 and 16 should be quite satisfactory evidence.

At the first meeting of the committee there was an extended discussion of the scope of the project. It was the consensus that any member of the committee could individually formulate a professional services index which would be satisfactory to himself; it also was agreed that in all probability such an index would not even be acceptable to the other members of the committee. As an extension of this thinking, it was pointed out that while there are many existing schedules and relative value indices, which are highly acceptable to those who developed them, there was no existing schedule, either fee or relative value, which was acceptable on any nationwide basis.

*Presented at the New England Blue Shield Professional Relations Seminar held at the Colony Motor Inn, Cranston, Rhode Island, September 23, 1961.

Goals

With this background it was agreed that the efforts of the committee should be directed to the preparation of a professional services index for national use on an entirely new basis. It was established that the two goals to be established were: first, to provide the National Account Agreement with a high degree of uniformity of professional services and payments by the individual Plans and to provide for increased flexibility; second would be the achievement of a composite professional services index which would provide local Plans with a specific outline in conformity with which they might develop their individual local schedules.

We of the committee felt that the keynote for success of this entire project was physician cooperation; that the index should be accepted, not because the committee recommended it, or the Board of Directors and the Conference of Plans had approved it, but rather that through the efforts of physicians throughout Blue Shield, the practicing physician would recognize the usefulness of this professional services index in providing an objective approach to the solution of a pressing and immediate problem.

Ground Rules

The ground rules which the committee established were very significant and in your consideration of this project you should be aware of this important background information:

1. It was agreed that there would be no consideration of dollar amounts, as such, in determining the indices.

2. There was no preconceived idea of the pattern which the results themselves would eventually establish.

3. It was also agreed that during the development of the composites there would be no periodic measurements of the composites against the fee schedules of the Plans represented by the members of the committee with the idea of determining how the composites would affect our own schedules.

4. We recognized that there were limitations existing in the material to be used, as for example, the varying periods of usual aftercare included in the specified fees, and we accepted them with full knowledge of their existence.

5. We agreed that a uniform professional services index was an ultimate necessity for Blue Shield Plans, both nationally and locally, and we were prepared to develop it.

6. We recognized that the development of any such index as we had in mind would necessarily require compromises by all the Plans. The compromise would obviously have to be based on somewhat arbitrary criteria, but we proposed that these criteria be made as acceptable as possible to all Plans.

Basis

With these ground rules established, we felt that the basis for the professional services index should be both the broadest, and the fairest, possible and we proposed to make use of pertinent information from all Blue Shield Plans. By doing so, we could work with the most current and practical medical economic information available anywhere in the country; we would be dealing with the manner in which a vast segment of present-day medical care costs are being paid for almost fifty million Americans. In our opinion, this practical information would be much more useful and objective than the theoretical economics of medicine which many groups have used in previous studies.

The resultant professional services index reflects the median basis on which all professional fees are currently being paid for all present Blue Shield members. In this project every Plan has contributed its representative share and every Plan has been equally influential in the results. It seemed to the committee that we had provided the ultimate in the democratic approach to the development of the professional services index. The committee was in complete agreement that the methods we employed in the development of this professional services index might be open to criticism, but the committee also agreed that such criticism was acceptable *only* if a practical alternative was suggested at the same time.

With this background the committee developed the methodology to be employed in creating the index and this represented the second phase of the program. We began the development of the index, *per se*, by using 35 surgical procedures which in over-all Blue Shield experience were those with the highest utilization.

Appendectomy was selected as the base procedure to which all other procedures were to be related. Using the "best" (most recent) fee schedule of each of the 69 U.S. Blue Shield Plans, allowances for each of 35 additional important cost procedures were determined. For each schedule, relationships were computed by dividing the 35 procedures allowances by the allowance for appendectomy. These relationships were grouped by procedure and the median was selected as the index. After extended study and discussion of this composite index by the committee, it was the decision that the final composite index should represent the median of four separate curves.

Accordingly, four index curves for the 35 procedures were prepared:

The first curve was limited to Service Benefit Plans.

Second, a similar curve was prepared using only Indemnity Plans.

continued on next page

Third, another curve was prepared using only the information from all Plans with over one half million members. This step was felt to be important to the development of a truly practical composite since these 28 Plans were the ones most concerned with National Account Agreements, or with fee schedules involved in employee-management bargaining for medical care contracts, and most significantly, that they represented approximately 83 per cent of all annual dollar disbursements for Blue Shield Medical Care.

The fourth and last curve was developed using only Plans which had relative value schedules and represented a composite curve of existing relative value indices which were in actual use.

From these four independent curves, the final curve which represented the composite of the four basic curves was developed.

This committee report received the unanimous approval of the Board of Directors and of the Conference of Plans. In recommending approval of the index the reference committee had noted that it was "... a significant milestone in the history of Blue Shield development" and added, "Let us get about the business of putting the program this report describes to work in securing a better future for ourselves and those we serve."

In conformity with the directive to complete the index, the third phase of the development took place promptly. The 35 original surgical procedures were expanded to 270 procedures which included all of the surgical procedures represented in approximately 80 per cent of the annual surgical disbursements of all Blue Shield Plans.

Second, four subcommittees of the index committee were appointed to develop indices for medical (non-surgical) services, for radiology, for anesthesia, and for clinical laboratory, using the same method employed in the surgical index insofar as it was possible and to whatever extent it could be applied. Due to the tremendous volume of paper work required in this phase, it was necessary to have the assistance of several claims executives from Blue Shield Plans and they spent two weeks in Chicago continuously employed in completing this phase of the development.

The fourth phase in the development of the index was the extension of the surgical index from the 270 procedures to all of the procedures which are usually specified in a majority of payment schedules of Blue Shield Plans. This was accomplished by the same subcommittee of claims executives who had worked on the completion of third phase.

There were a few exceptions to the general methodology employed in developing the index which should be brought to your attention. It was the consensus of the committee that having been entrusted with the responsibility to develop the index on the basis we had set forth we should, in good faith, inform the Plans of any differences from the established pattern which were found to be necessary.

First, it was discovered that nine of the fourteen indemnity plan fee schedules had total dollar limitations which effectively put ceilings on benefits for the higher cost procedures as was evident on the chart of the indemnity plan curve. With more than one half of the indemnity plans thus involved a ceiling was automatically placed on the curve for this category. We considered this limitation to be an artifact which would, without validity, have the adverse effect of depressing the determination of the final composite professional services index. The median index of all Plans was substituted as the median for the indemnity Plans.

Second, while the original method employed in the index for appendectomy was the base line of 35 units, further study indicated that 36 was a more convenient, practical factor than was 35. This is simply because using 36 (an even number) as the unit base, various factors such as 1/12, 1/10, 1/8, 1/6, 1/3, and 1/2 may be determined without the awkward fractions which result from the use of an uneven number such as 35 units as a base. This substitution does not affect the validity of the index and the choice of the index number to be used as a base is entirely arbitrary and any convenient number could be used.

Third, the professional services index for the medical (nonsurgical) professional services is not considered to reflect the current practice of internal medicine by the American Society of Internal Medicine representatives who requested and were accorded a meeting with the index committee. It was pointed out to these officers that there is considerably less material available from the Blue Shield Plans on medical coverage than in the area of surgery; that the index for Internal Medicine, as developed by the committee, has the same validity as does the index developed for surgical procedures; and finally, as has been stated repeatedly, that the Professional Services Index is not intended to project what type of fee schedules should be developed, but rather to reflect the existing pattern of payments for professional services. These are the only substantial modifications of the basic principles of the index which were found to be necessary.

We were pleased that the professional services index was brought to the attention of the House of Delegates of the American Medical Association in the report of the Council on Medical Services at the Annual Meeting in New York on June 24. At the conclusion of its report the Council commended to the individual state medical associations a careful study of this National Professional Services Index. This recommendation was adopted by the House

of Delegates on June 28. It was, of course, a most satisfactory and significant action not only to the members of the committee and others who had worked in developing the index, but also to the officers and the constituent Plans of National Blue Shield.

In my opening remarks I noted that the index committee had two goals toward which to work. The first was to provide the National Account Agreement with a more flexible and uniform basis and the second was to provide an outline in conformity with which local Plans might wish to develop their individual fee schedules. I should like to take a few minutes to comment on the adaptation of the Professional Services Index to local Plan situations. The application of the index to the National Account Agreement will be discussed at the Program Conference of National Blue Shield in Chicago in October.

We believe that the application of the Professional Services Index to the arrangement of local Plan fee schedules will accomplish several distinct advantages for the Plan:

1. It will enable the local Plan to create a fee schedule which will be in conformity, as far as professional relationships go, with the median of all Blue Shield fee schedules.

2. It offers the Plan an opportunity to correct inequities which have crept into existing fee schedules over the years.

3. It provides an authoritative base line for the arrangement of fee schedules since it was developed on the broadest possible basis using the best contracts of all Blue Shield Plans.

4. It offers an objective approach to the establishment of the proper relationships between the several types of professional services. This consideration is of tremendous practical importance since it assists the local Plan in avoiding pressure which may be exerted by certain types of specialty practice to secure more favorable fees, the end result of which is always an unbalanced fee schedule.

As to the practical method by which the Professional Services Index may be applied, it is not to be expected that any index such as the Professional Services Index may be applied in its entirety to any existing fee schedule in a single step. To do so would be to seriously disturb the relationships of many individual fees which locally are higher than the index indicates they should be. In addition, it is not necessary to do the conversion in a single step since the major principle of the Professional Services Index is a long-range project through which eventually a higher degree of conformity to acceptable relativity between professional services will be achieved. The index, as we conceive it, is a fluid arrangement that will be adjusted from time to time to reflect improved payment policies of individual Plans.

The first practical step should be the acceptance of the index and the assignment of an appropriate unit value which will satisfactorily increase a majority of existing fees. All fees currently used which are in excess of the fees indicated by the index should remain at their present level.

The second step in the application of the index should come when the fee schedule is next subject to revision. At that time a proper increase of the unit value will apply not only to fees already based on the index but will have the effect of including a large majority of the fees which were exceptions to the index in its first application. In a majority of cases the second revision of the fee schedule according to the index should place substantially all professional service fees on the basis of the index. In some instances, depending on the basic differences which exist between the relationship of the original fee schedule and the Professional Services Index, it may be necessary that a third upward revision of the fee schedule (with an increased unit value) be used before the entire fee schedule is based on the index.

The number of steps which will be necessary to bring about conformity of a local fee schedule to the Professional Services Index is not the significant consideration. The most important element in the project is that all Plans be willing to take the first step as promptly as possible. This consideration in itself would be a most constructive development in this effort to achieve a rational approach to professional services payment.

As has been pointed out repeatedly, the use of the professional services index relationships does not in any manner attempt to fix the level of local Plan fees except in their relationship to all other local fees. It is the local Plan itself which will establish the unit value at which all professional services will be paid on any particular contract using the Professional Services Index.

I am sure many individuals in Blue Shield as well as many practicing physicians are still skeptical of the necessity for the successful, continued development of the project; nevertheless, they have given practical evidence of their faith in the leadership and of their willingness to co-operate without reservation. This circumstance makes it doubly important that the project does not fail. Just as in the development of the Professional Services Index we did not cut corners or make arbitrary decisions in order to produce the situation which might mollify some of those who we anticipated might be critical, just so in the future, we must hew to the line of absolute factual material leaving the Participating Physicians of the local Plans to judge for themselves their willingness to pursue the course which the leadership, based on the factual material, may recommend.

This commentary on the Professional Services

concluded on next page

Index would not be complete without a few observations regarding the importance of the index to both the individual Plans and the National Association.

What does the acceptance of the Professional Services Index mean to the future of Blue Shield Plans?

In a single sentence, it may mean their very existence.

It is a firm basis on which we can build better and broader schedules for payments of professional services; in its concept it is flexible and will continually reflect a massive segment of the economics of medical care across the country. It will provide a means for the achievement of a very high degree of uniformity of the pattern of benefits, of equitable (though variable) professional fees without interfering with the local control of Blue Shield Plans by their Participating Physicians.

All of these considerations spell out more effective availability of Blue Shield to the American people; a greater opportunity for the medical profession to serve the American public through expansion of the Service Benefit principle.

The last precept is most important and while I have stated it as a positive benefit which will accrue to the American people, there is great danger that it may become a negative one. If so, Blue Shield will have lost its greatest opportunity to fulfill the purposes for which it was established.

I would ask you to recall that the ultimate purpose of Blue Shield is not the achievement of National Accounts; it is not the question of whether Blue Shield or the insurance industry can better serve the Health Benefits Program for Federal Employees; it is not that Blue Shield become the largest single organization providing benefits for professional services of doctors of medicine; the ultimate purpose of Blue Shield is to provide Service Benefit coverage for all insurable medical care for all of the American people who must work for a living and whose incomes are not in the higher financial brackets. The degree to which this ultimate purpose is accomplished is the only significant criterion of the successful operation of Blue Shield, whether of an individual Plan or all of the Plans in aggregate.

The development of the "biggest," the "highest," the "widest," and the "longest" of anything is a familiar American aspiration. Frequently our seeming dedication to the achievement of superlatives in materialistic things terrifies visitors to our country; just so with Blue Shield, some of us are very fearful that having attained our majority, having placed ourselves in a position in which we can compete effectively in the national health care market, we may become so engrossed with our size that we will be ready to make any concession of principle to continue to increase the magnitude of our operations. I personally believe we already have some evidence that this is taking place; if so, it is a tragic mistake. An increase in our size, for the sake of size alone, may be progress, but it is not Blue Shield progress; it is insurance progress, but Blue Shield is not insurance.

Blue Shield is simply the mechanism by which practicing physicians, through participation, can adapt the traditions of medical practice to the circumstances of present-day prepaid medical care.

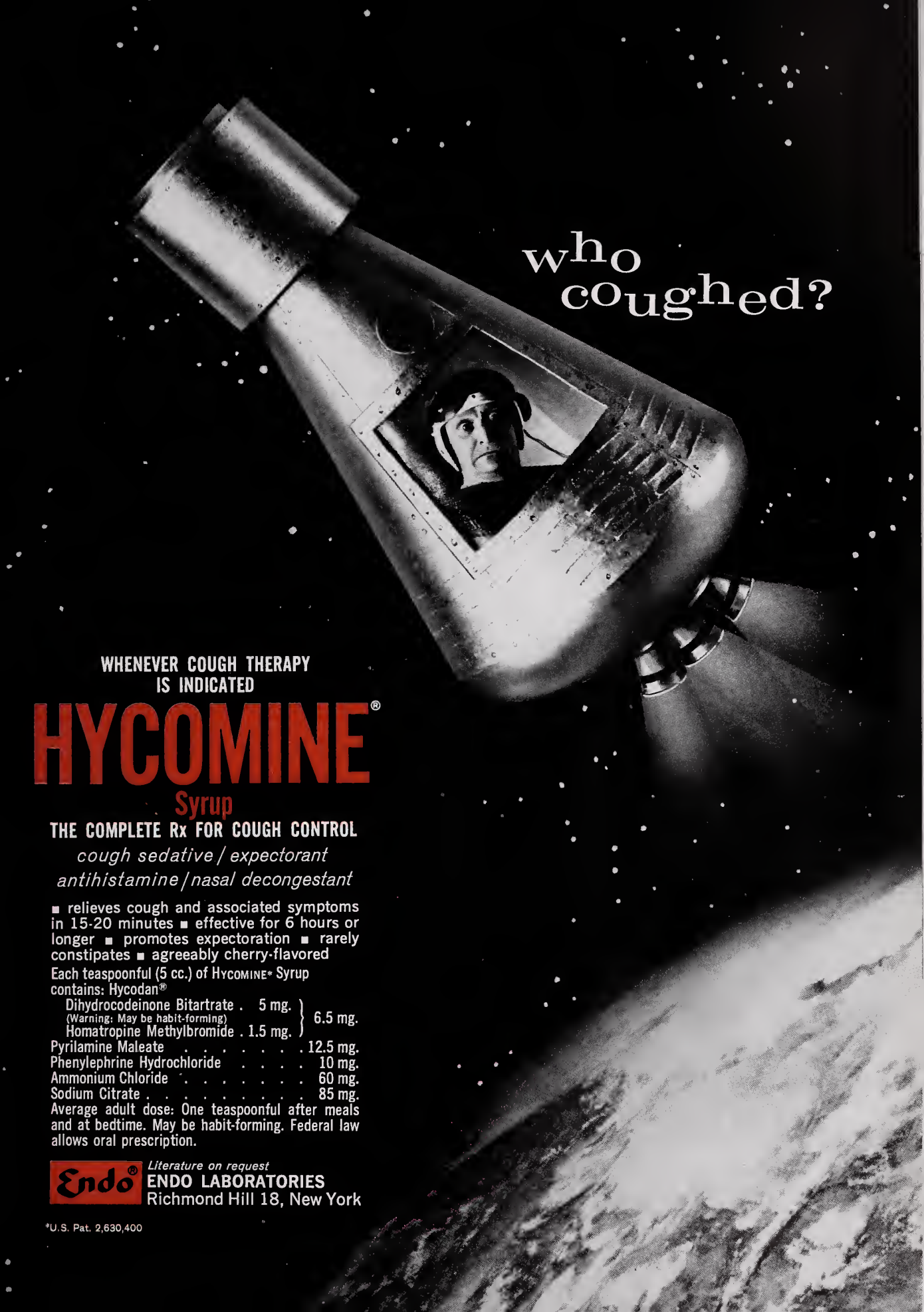
Having recounted at this length the manner in which the professional services index became a reality, I should like to identify for you the members of the committee and my associates without whom the project could not have been accomplished. The members of the committee were: C. Willard Camalier, M.D., Board of Directors, Medical Service of District of Columbia, Washington, D. C.; Paul Hoagland, M.D., Board of Directors, California Physicians' Service, Pasadena; Max L. Lichter, M.D., Board of Directors, Michigan Medical Service, Detroit; Mr. William H. Love, Executive Assistant, Illinois Medical Service, Chicago; H. R. Pezzuti, M.D., Medical Director, Medical Service Association of Pennsylvania, Camp Hill; and Leonard J. Raider, M.D., Vice President, United Medical Service, Inc., New York.

Mr. Listro, director of Underwriting & Research at CMS, worked with me in the initial experimental statistical work and Mr. Knebel of Indianapolis, now Statistical-Research manager of National Blue Shield, did an outstanding job in carrying out the analytical and statistical computations in conformity with the principles arrived at by the committee.

Mr. Bierkan, director of Claims & Physicians Relations at CMS, Doctor Safian, associate medical director of UMS, and Mr. Knebel worked as a subcommittee with Mr. Love of the index committee in the expansion of the surgical schedule and the development of essential underwriting controls.

Mr. Castellucci, executive vice president of National Blue Shield, co-ordinated the work of the index committee with the committees on Blue Shield enrollment and the National Account Agreement.

The creation of the Professional Services Index represents a tremendous potential for Blue Shield. It provides the basis for a uniformity of action that will again make Blue Shield foremost in the coverage of medical care costs. This leadership can be either as indemnity health insurance, or as Service Benefits, depending on whether or not Blue Shield adheres to the basic principles that made it what it is. If it becomes indemnity health insurance, it will be the most formidable competitor the insurance industry has yet had to face; but Blue Shield will no longer be Blue Shield. If it remains dedicated to the ultimate purpose of Blue Shield — Service Benefits — it will make this unique Blue Shield concept available to the working people.



WHENEVER COUGH THERAPY
IS INDICATED

HYCOMINE®

Syrup

THE COMPLETE Rx FOR COUGH CONTROL

cough sedative / expectorant
antihistamine / nasal decongestant

■ relieves cough and associated symptoms in 15-20 minutes ■ effective for 6 hours or longer ■ promotes expectoration ■ rarely constipates ■ agreeably cherry-flavored

Each teaspoonful (5 cc.) of HYCOMINE* Syrup contains: Hycodan®

Dihydrocodeinone Bitartrate (Warning: May be habit-forming)	5 mg.	6.5 mg.
Homatropine Methylbromide	1.5 mg.	
Pyrilamine Maleate		12.5 mg.
Phenylephrine Hydrochloride		10 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

Average adult dose: One teaspoonful after meals and at bedtime. May be habit-forming. Federal law allows oral prescription.

Endo®

Literature on request
ENDO LABORATORIES
Richmond Hill 18, New York

*U.S. Pat. 2,630,400

AMERICAN MEDICAL ASSOCIATION

Fifteenth Annual Clinical Session

November 26-30, 1961, at Denver, Colorado

REPORT ON ACTIONS OF THE HOUSE OF DELEGATES

CHARLES J. ASHWORTH, M.D., *Delegate*
ARTHUR E. HARDY, M.D., *Alternate Delegate*

OUTSTANDING among the accomplishments of the House of Delegates of the American Medical Association at the Denver meeting was the alert sounded by Leonard W. Larson, M.D., president of the American Medical Association, in his address to the House. The reading of his entire speech is a must for every practicing physician and will be found in the December 9 issue of the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. A short quote from that speech, however, would not be amiss in this report. He said, "We are engaged in a historic struggle to preserve our country's unique system of medical care and our stature as a profession. Both are seriously threatened by current proposals to incorporate health care benefits into the Social Security system. . . ."

"First, why do we fight? We fight because we have dedicated our lives to providing the best medical care possible to all our patients . . . we fight for our patients and their well-being. We fight because the administration's medical care proposal, if enacted, would certainly represent the first major, irreversible step toward the complete socialization of medical care. A proposal which places the primary responsibility for the purchase of health care on the federal government, financed by compulsory payroll taxes and equivalent taxes on employers, administered directly by the Social Security Administration, providing benefits without regard to financial need, and for which the federal government has no logical responsibility — certainly such a proposal can properly be categorized as 'socialized medicine.'"

In closing, he used an appropriate quotation from a speech by Senator Kerr to a group of physicians, who said, "I would not discourage you, because the task is not hopeless — but it's not self-executed. You have probably the greatest opportunity of any generation of your profession that has ever lived, and all future generations of your profession are going to know whether or not you did your part in keeping the environment for them that has been such a blessing to you. If you do what you are capable of doing and the rank and file of those identified with you across the nation join you, you can tell your children that you made the fight that kept for you the environment which has been your blessing — and passed it on, unimpaired and unsullied, to those that you love even more than you do yourself."

The compelling issue, Doctor Larson declared, is socialization *versus* voluntarism — or compulsion *versus* freedom of choice. He predicted that courage, determination and the will to win on the part of physicians will bring the defeat of the King-Anderson bill in Congress next year.

He further emphasized that the A.M.A. will continue to give primary attention to implementing the Kerr-Mills Act in the states, promoting voluntary health insurance and prepayment plans designed for the aged, and upgrading nursing homes.

The House of Delegates gave enthusiastic approval to Doctor Larson's address and took several actions reaffirming strong support for the Kerr-Mills program to aid the needy and near-needy aged, and urging a concerted, determined fight against Social Security health care proposals in Congress.

The House advised all state and county medical societies to recognize the impending threat and to prepare now for any eventuality by continuing to oppose any scheme which tries to impose a substandard system of medical care on the American people.

"United, as well as individual, effort is essential," the House declared. "To stop short of our total effort is to invite disaster and to let loose upon our beloved America irreversible forces which will ultimately destroy her. We cannot and we must not fail."

In addition to Social Security health care, relations with the American College of Surgeons, organization of the American Medical Political Action Committee, medical discipline and polio vaccine were among the major subjects acted upon by the House of Delegates.

The House agreed with the intent of five resolutions which expressed strong dissatisfaction over

continued on page 50



after surgery: vitamins are therapy

Nutritional supplementation is basic to postoperative care. Therapeutic allowances of B and C vitamins help meet increased metabolic requirements and compensate for stress depletion. STRESSCAPS can set the patient on a more favorable course and contribute to full recovery. Packaged in decorative "reminder" jars of 30 and 100.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

STRESSCAPS®

Stress Formula Vitamins Lederle

A.M.A. HOUSE OF DELEGATES

continued from page 48

recent statements by a spokesman for the American College of Surgeons, and it also approved a Board of Trustees report informing the House that arrangements have been made for a January meeting with the ACS Board of Regents to discuss that organization's recent statements and policy positions. The report expressed hope that the meeting "will lead to a unification of effort in behalf of American medicine."

The House instructed the Board of Trustees to take the five resolutions to the January meeting and to report to the delegates as soon as possible on the results of the meeting. In taking the action, the House approved a reference committee report which said:

"Your reference committee believes the public airing of disagreements between large segments of medicine can only confuse and shake the confidence of the public in the medical profession and distort the true image of medicine which the American people should have.

"However, in its hearings upon the several resolutions relating to the recent statements of the American College of Surgeons, all those who testified were in opposition to the actions and statements of the ACS. The majority of those who spoke were Fellows of the American College of Surgeons.

"Your reference committee has no wish to fan the flames of controversy ignited by the statements of the American College of Surgeons. On the other hand, the committee feels the House has an obligation to its membership — which includes physicians in all types of practice — to agree with the indignation manifested by the introduction of these resolutions and in the discussions before the committee.

American Medical Political Action Committee

The House heartily approved the purposes and goals of the recently-organized American Medical Political Action Committee and urged all physicians, their wives and interested friends to join AMPAC and other political action committees in their states and communities.

"Effective political action must be carried on at the local level and effective implementation must be done by local groups of physicians," the House said. "The formation of AMPAC recognizes the need for a national medical political action committee to co-ordinate the political activities of physician groups at all levels throughout the country."

The purposes of AMPAC, which is an organization separate and distinct from the American Medical Association as required by federal law, are:

1. To promote and strive for the improvement of government by encouraging and stimulating physicians and others to take a more active and effective part in governmental affairs.

2. To encourage physicians and others to understand the nature and actions of their government as to important political issues and as to the records and positions of political parties, officeholders and candidates for elective office.

3. To assist physicians and others in organizing themselves for more effective political action and for carrying out their civic responsibilities.

4. To do any and all things necessary or desirable for the attainment of the purposes stated above.

Medical Discipline

The House received from the Council on Constitution and Bylaws a proposed amendment which would have made it possible to implement a recommendation by the Medical Disciplinary Committee that was approved by the House at the June, 1961 meeting. This recommendation was to change the bylaws so as to confer original jurisdiction on the Association to suspend and/or revoke the A.M.A. membership of a physician found guilty of violating the Principles of Medical Ethics or the ethical policies of the Association, regardless of whether or not action has been taken against him at the local level. However, after considerable discussion on the floor of the House, the proposed amendment was referred back to the Council on Constitution and Bylaws.

In another action on medical discipline the House approved the expanded activities of the Judicial Council, which has taken over permanent responsibility in that area, and said that the Council program should benefit all physicians, the public and the profession.

Polio Vaccine

Medical societies at the local, county, district or state levels throughout the United States should encourage, stimulate and participate in surveys to determine the percentage of individuals in each community who have undergone immunizing procedures for poliomyelitis.

The resolution, adopted by the House, stated that on the basis of the results of the surveys, the local

J. E. BRENNAN & COMPANY
Leo C. Clark, Jr., B.S., Reg. Pharm.
Apothecaries
Two Convenient Locations
5 North Union Street — Pawtucket, R. I.
140 Central Avenue — Seekonk, Mass.
7 Registered Pharmacists
Pharmacy License #226

medical society should determine the type of vaccine and the most effective type of program which will be of greatest benefit to the public.

Until such time as all three types of oral vaccine are available, the resolution concluded, the Salk vaccine should be the vaccine of choice for routine poliomyelitis immunization, with the choice of program for administering the vaccine to be determined on a local basis by each county medical society.

The House also: recommended, as a civil defense measure, a *mass immunization* program for the general public.

Suggested that the Board of Trustees continue its negotiations to develop a group *disability insurance* program for A.M.A. members.

Concurred in the Board's appointment of a special committee to study the organizational status of *A.M.A. Sections*, the functions of the Scientific Assembly and existing procedures for establishing medical certifying boards.

Instructed the Council on Medical Education and Hospitals to study the present and potential contribution of the *American Board of Abdominal Surgery* to the advancement of the art and science of surgery and the betterment of public health, to determine whether it should be approved as a recognized examining board.

Approved and commended the objectives and program submitted by the Committee for Liaison with *National Nursing Organizations*.

Recommended that the secretary of Defense consider the advisability of developing a training program for *reserve medical* officers.

Disapproved of two proposals which would have required that *resolutions* be introduced 30 and 45 days, respectively, before Association meetings.

Approved a statement that physicians have an *ethical obligation* to participate in medical society activities and express their opinions fully and freely.

Reaffirmed A.M.A. policy that it is not considered unethical for a physician to own or operate a *pharmacy* provided there is no exploitation of the patient.

Agreed with the Judicial Council that the physician himself is responsible for the control and custody of *drug samples* once they come into his possession, and in the high tradition of the medical profession he should not dispose of them in any way that could cause harm to others.

Agreed with the Board's choice of Miami Beach, Florida, as the site for the *1964 Clinical Meeting*.

Approved the combining of the *American Medical Education Foundation* and the *American Medical Research Foundation* into the *American Medical Association Education and Research Foundation*, effective next January 1.

Deferred action on a proposed study of *fund raising* by voluntary health agencies, pending the development of additional information by the A.M.A. Committee on Voluntary Health Agencies.

Reaffirmed the previous policy that physicians should have the privilege of prescribing drugs by either *generic or brand name*.

Approved the principle of *income tax deductions* for medical care of the aged.

Commended those constituent medical societies which have moved forward in the area of *human relations* by eliminating membership restrictions based on race or color.

Approved a recommendation that a special House committee be appointed to investigate all facets of the operation of the *Joint Commission on Accreditation of Hospitals*.

Urged the elimination of all "categories" in programs of *assistance to the needy* at the federal and state level, with all assistance provided through a single program.

Referred to the Council on Medical Service a resolution proposing the use of state and federal tax funds to provide voluntary prepayment health insurance protection for the aged. In a related action the House approved of experimentation with *prepayment plans* under assistance programs.

Urged more vigorous promotion of voluntary nonprofit prepayment health plans.

Urged every physician in the United States to use automobile *seat belts*.



Fuller

Memorial Sanitarium

Located on Rt. 1

South Attleboro, Massachusetts

A modern non-profit hospital for the care and treatment of nervous and emotional disorders as well as long term geriatric problems.

Physical, neurological, psychiatric and psychological examinations.

Modern recognized psychiatric therapies.

A pleasant homelike atmosphere in a beautiful and conveniently located institution.

L. A. Senseman, M.D., F.A.P.A., Medical Director
Edwin Dunlop, M.D. Michael G. Touloumtzis, M.A.
Oliver S. Lindberg, M.D. William H. Dunn, M.S.W.
W. H. Lesovsky, M.D., Ph.D.

Referred patients are seen daily (except Saturdays) 9-12 A.M., and by appointment.
R. I. Blue Cross Benefits Tel. Southgate 1-8500

Special Rates for Long-Term Care

NECROLOGY, 1961 — THE RHODE ISLAND MEDICAL SOCIETY

GEORGE W. ASHTON, M.D., died on September 25, 1961.

Doctor Ashton was born in Stockbridge, Massachusetts, on September 24, 1873. He was a graduate of Williams College and he received his medical degree from the University of Maryland in 1905.

He was one of Rhode Island's last country doctors and he delivered his 3,000th baby when he was eighty years old. Doctor Ashton retired from active practice about ten years ago, although he continued to treat a few old patients.

Doctor Ashton was a member of the Woonsocket District Medical Society, the Rhode Island Medical Society, and the American Medical Association.

MORRIS BOTVIN, M.D., died on September 12, 1961.

Doctor Botvin was born in Providence on December 9, 1910. He was a graduate of Classical High School and of Brown University, class of 1932. He received his medical degree from Tufts University Medical School, *cum laude*, in 1936. He then interned at St. Luke's Hospital, New Bedford, Massachusetts.

He served residencies at Boston City Hospital, the Boston Floating Hospital, and Boston Children's Hospital.

A World War II Army veteran, he served as a major in the medical corps in the South Pacific area. At the time of his death he was chief of ophthalmology at Miriam Hospital and attending ophthalmologist at Rhode Island Hospital, and at Notre Dame Hospital, Central Falls.

He was a member of Temple Emanu-El, Touro Fraternal Association, a charter member of Plantations Lions Club, a director of the Lions Club, chairman of the Eye Foundation and past president of the Rhode Island Ophthalmological Society.

Doctor Botvin was also a member of the Providence Medical Association, the Rhode Island Medical Society and the American Medical Association. He was a fellow of the American College of Ophthalmology and Otolaryngology, a member of the American Board of Ophthalmology and a past consultant at the Veterans' Administration.

JAMES G. CHAPMAN, M.D., died on April 8, 1961.

Doctor Chapman was born in Nevada, Iowa, on November 1, 1915. He received his bachelor of science degree from La Sierra College, La Sierra, California. In 1944 he was graduated from the College of Medical Evangelists, Los Angeles, with the degree of doctor of medicine. He did postgraduate work in surgery at Cook County Hospital, Chicago.

He was a member of the Pawtucket Medical Association, the Rhode Island Medical Society, and the American Medical Association.

FRANK T. FULTON, M.D., a practicing physician in Providence for more than fifty years, died on April 10, 1961.

Doctor Fulton was born in Westmoreland County, Pennsylvania, on April 28, 1867. He was graduated from Knox College, Galesburg, Illinois, in 1894, and from Johns Hopkins University Medical School in 1899. He served for a year as an intern at the Boston City Hospital before coming to Rhode Island.

During the early years of the century, he was an instructor in histology at Brown University. He later was cardiologist at the Providence Lying-In Hospital.

In World War I he was commissioned a major in the Army Medical Corps and served as chief of the medical staff at the base hospital, Camp Devens, Massachusetts. He also developed the "heart station" at Rhode Island Hospital and served as a consultant there for many years.

Doctor Fulton was a member of the consulting staffs of Rhode Island Hospital, Providence Lying-In Hospital, the Memorial Hospital in Pawtucket, and South County and Westerly hospitals.

He was president of the Providence Medical Association in 1921 and was president of the Rhode Island Medical Society in 1929. From 1933 to 1935 he served as president of the New England Heart Association.

JOSEPH F. HAWKINS, M.D., an eye, ear and nose and throat specialist in Providence for more than fifty years, died on December 6, 1961.

Doctor Hawkins was born in Providence on August 1, 1872, and he was graduated from Classical High School in 1892 and received his medical degree from Harvard Medical School in 1896. After his graduation he studied in Europe for

eighteen months.

He served as an enlisted man in the Spanish-American war and as an officer and surgeon in World War I. He was discharged in 1919 with the rank of lieutenant colonel. After the war he was active in the American Legion and was a past commander of Providence Post No. 1.

Doctor Hawkins volunteered for service in World War II, but because of his age he was limited to consultive service.

He was a member of the Providence Medical Association, the Rhode Island Medical Society, the American Medical Association, the New England Ophthalmologic Society, of which he was a past president, and he was also a member of the Military Order of Foreign Wars and the Military Surgeons of the World War.

SAMUEL I. KENNISON, M.D., died on October 14, 1961.

Doctor Kennison was born in Philadelphia on July 31, 1892. He was educated at Colt Memorial High School and was graduated from Brown University in 1913 and from Harvard Medical School in 1917.

From 1917 until 1921 he served in the Navy as a lieutenant in the medical corps. After the war he returned to Rhode Island to practice medicine. He was a member of the Jewish War Veterans and in 1925 served as commander of local Post 23 and as national vice commander.

Doctor Kennison was a pathologist at the Newport Hospital from 1918 until 1921, and from 1923 to 1950 he was associated with Miriam Hospital as a pathologist and psychiatrist. He was also visiting psychiatrist at Charles V. Chapin Hospital from 1932 to 1950.

He was a member of the Providence Medical Association, the Rhode Island Medical Society, the American Medical Association, the New England Neurological Association, and the American Psychiatric Association. In 1928 he was the president of the Jacobi Medical Club of Providence and from 1932 to 1933 he was president of the Miriam Hospital Staff Association. He was also a 32nd degree Mason.

JOHN A. MACK, M.D., died on August 28, 1961.

Doctor Mack was born in Proctorsville, Vermont, on June 4, 1872. He was graduated from the University of Vermont Medical School in 1895, and then he interned at the New York Maternity Hospital for two years before coming to Rhode Island, where he established a practice in Warwick at the age of twenty-six.

Doctor Mack was the oldest practitioner of medicine in the Pawtuxet Valley at the time of his death. He was a former president of the Kent County Medical Society, and treasurer of the Society for thirty years. For many years he was secretary of the Pawtuxet Valley Tuberculosis and Visiting Nurses Association.

He was a charter member of the J. P. Gibson Council, Knights of Columbus, and a charter member of the Friendly Sons of Saint Patrick of the Pawtuxet Valley. He was a member of the West Warwick Elks Lodge and the Father Wallace Assembly, fourth degree, Knights of Columbus. The Gibson Council, Knights of Columbus, honored Doctor Mack as a founder of the council shortly before his death, and the Kent County Medical Society presented him with a framed resolution as dean of Valley physicians in August, 1960.

He was West Warwick health officer from 1939 until December, 1960, when he retired because of illness. Besides his membership in the Kent County Medical Society, Doctor Mack was also a member of the Rhode Island Medical Society, the American Medical Association, and he was on the staffs of Kent County Hospital and St. Joseph's Hospital.

JAMES A. McCANN, M.D., for many years a practicing surgeon in Providence, died on March 31, 1961.

Doctor McCann was born in Providence on September 27, 1881, and after attending local schools, he was graduated from Brown University in 1904 and from Johns Hopkins Medical School in 1908. He interned at Rhode Island Hospital and at Providence Lying-In Hospital.

For many years, he was a visiting surgeon on the gynecological staffs at Rhode Island and Charles V. Chapin hospitals, a consultant at Lying-In Hospital, and was on the courtesy staffs at Miriam and St. Joseph's hospitals.

He was a fellow of the American College of Surgeons and the New England Gynecological Society, and a member of the Providence Medical Association, the Rhode Island Medical Society, the Johns Hopkins Surgical Society and the Pithodomy Club, honor society at Johns Hopkins.

ALFRED F. MELUCCI, M.D., died on April 11, 1961.

Doctor Melucci was born in Pawtucket on April 20, 1906. He was graduated from Tolman High School, from Providence College in 1929, and he received his medical degree from the School of Medicine at Saint Louis University in 1936.

He enlisted in the Army in 1942 and served at various hospitals during the Second World War.

Doctor Melucci held membership in the Pawtucket Medical Association, the Rhode Island Medical Society, the American and World Medical Associations, the Holy Name Society of St. Mary's Church, and the Pawtucket-Blackstone Valley Chamber of Commerce.

continued on next page

ARTHUR H. RUGGLES, M.D., a nationally recognized leader in the field of mental hygiene, died on January 2, 1961.

Doctor Ruggles was born in Hanover, New Hampshire, on January 26, 1881, and he attended Hanover schools and Dartmouth College, where he received the degree of Bachelor of Arts in 1902. He obtained his medical degree from Harvard Medical School in 1906 and then spent two years as an intern at Rhode Island Hospital before joining the staff of Butler Hospital as assistant physician.

In 1912 Doctor Ruggles went to Germany for study at the University of Munich and there came into touch with the revolution in psychiatry instituted by Sigmund Freud. Upon the outbreak of World War I, Doctor Ruggles became psychiatrist at a British war hospital in Scotland. When the United States entered the war, he was commissioned a major in the Medical Reserve Corps and organized the first neuropsychiatric unit in the American Expeditionary Force in France. He was for a time division psychiatrist to the Second Division and later was consultant in psychiatry for American hospitals in Europe. After the armistice he became medical director of a base hospital in France, and he was awarded the Croix de Guerre by the French government.

Upon returning to Rhode Island in 1919, Doctor Ruggles resumed his work at Butler Hospital, where he became superintendent in 1922, a post he held until his retirement in 1948. Recognition of the value of Doctor Ruggles' work, both locally and nationally, came to him in full measure over the years. He served as president of both the National Committee for Mental Hygiene and the American Psychiatric Association.

He was honored with the honorary degree of Doctor of Science by three institutions of higher learning. The degree was awarded him by Dartmouth College, his alma mater, in 1926, by Brown University in 1929, and by the University of Rhode Island in 1949.

A member and past president of the Rhode Island Medical Society, Doctor Ruggles also was a member of the American Medical Association and the Providence Medical Association. In 1947 he was elected president of the Council of the New England State Medical Societies, and he had also served as a trustee of the New England Hospital Assembly.

He was one of the organizers of the Rhode Island Society for Mental Hygiene and later was its president. He served as a director of the Providence Council of Social Agencies and as a chairman of its general survey committee.

JOHN W. SWEENEY, M.D., former head of the Department of Gynecology at Rhode Island Hospital, died on January 27, 1961.

Doctor Sweeney was born in New Haven, Connecticut, on July 1, 1878. He was a graduate of Hillhouse High School, Yale University and Yale Medical School, class of 1907. He interned at New Haven Hospital and also at Lying-In Hospital in Providence.

From 1910 to 1938 Doctor Sweeney was on the staff of Rhode Island Hospital where he was assistant surgeon for twelve years and was for a year chief of staff in the department of gynecology. He served for eighteen years in the early part of the century as visiting obstetrician at Lying-In Hospital. For three years he was an instructor in obstetrics at Tufts Medical School, and he was also consulting physician on the staffs of Rhode Island, Lying-In, St. Joseph's, Charles V. Chapin and Miriam hospitals.

Doctor Sweeney served in the Rhode Island National Guard for seven years until 1918 as regimental surgeon of the Engineers 11th Division at Camp Forrest, Georgia and Camp Mead in Maryland.

He was a member of the Providence Medical Association and the Rhode Island Medical Society.

GEORGE A. TOLLEFSON, M.D., a former Newport County medical examiner, died on May 31, 1961.

Doctor Tollefson was born in Newport in 1912. He was graduated from Rogers High School in 1930, attended the Belmont Abby School in North Carolina for two years, and then entered Georgetown University. He received his medical degree from the Georgetown Medical School in 1940.

After an internship at the Municipal and Columbia hospitals in Washington, he joined the Navy in 1942 with the rank of lieutenant commander in the Medical Corps. He saw service in the European, African and Pacific theaters and took part in the Okinawa operation and in the occupation of Japan.

After his discharge in 1946, Doctor Tollefson opened his office in Newport. In 1949 he was appointed medical examiner by the then Attorney General William E. Powers.

Doctor Tollefson was a member of the Newport County Medical Society, the Rhode Island Medical Society, the Georgetown Alumni Association, and the Naval Reserve Medical Corps.

CHARLES P. TUNG, M.D., died on August 6, 1961.

Doctor Tung was born on July 6, 1911, in Hofei, China. He was graduated from the Provincial University of Anh Wei, Anking, China, and from Yale-in-China Medical College in Cheng Sha, China, the University of Washington, and Long Island College of Medicine.

He was an instructor in surgery at National Shanghai Medical College, in China, and assistant professor of surgery at the Temporary University

Medical School in Nanking before coming to this country.

He was a member of the staff of Kingston Avenue Hospital, Brooklyn, New York, and a resident specializing in tuberculosis at the State Sanitarium, Gardner, New Jersey. He became a resident specializing in cancer surgery at Westfield State Sanatorium, Westfield, Massachusetts, in 1951. Five years later he became assistant superintendent of North Reading State Sanatorium at North Reading, Massachusetts. He opened his Rhode Island office in 1957.

Doctor Tung was a member of the Kent County Medical Society and the Rhode Island Medical Society.

JOHN G. WALSH, M.D., who delivered more than 12,000 Rhode Island babies during the forty-six years of his professional career, died on March 31, 1961.

Doctor Walsh was born in Providence on August 4, 1883. He was graduated from Classical High School in 1902, from Brown University in 1906, and he received his medical degree from Harvard Medical School in 1910. He interned at Boston City Hospital, Rhode Island Hospital, and Providence Lying-In Hospital.

He was the first generation of doctors who regularly and especially delivered babies. For thousands of working class families in Providence he was a revered legend.

Doctor Walsh was a past president of the Providence Medical Association, a past president of the New England Obstetrical and Gynecological Society, a former chief of the obstetrical department of Pawtucket Memorial Hospital, a fellow of the American College of Surgeons and of the Obstetrical Society of Boston, a diplomate of the American Board of Obstetricians and Gynecologists, a member of the American Medical Association and the Rhode Island Medical Society. A Knight of Malta in the Roman Catholic Church, he was also a steward and vice president of the Friendly Sons of Saint Patrick and a member of the Providence Lodge of Elks.

WHAT IT'S LIKE TO PRACTICE UNDER SOCIALIZED MEDICINE

concluded from page 31

could be a destructive influence on the older population. Though health care of the elderly is often more expensive than that of younger persons, the British found that their attempts to improve the health services for the minority down-graded the services for the majority.

The dissatisfaction with the National Health Service has been strikingly shown in the sharp rise in voluntary health insurance plans in Britain. When the Health Service first was established, private health insurance fell off drastically. But now those who can afford it buy private health insurance because of the better treatment and benefits it assures, though the insured must also carry the heavy taxes that pay for the nationalized health plan.

The poor British taxpayer has been milked dry. The Health Service now costs more than five times the original estimate. One of the main reasons is that there are two or three government clerks for each doctor. On that basis, if the U.S. adopts a government operated health system, the federal government would have to hire nearly two million more clerks. When the British Health Service began, the staff of the hospital where I was an intern seemed to double over night. The signs of bureaucracy — excessive paperwork, overhead and impersonal treatment—were immediately apparent. Hospitals apply to the government for block grants for operating expenses. If a hospital has any money left over when it has completed a fiscal year, the next year's grant is reduced by this amount. Naturally, this system encourages wasteful practices and penalizes economical hospital administrators.

Patients and pharmacists were not guiltless either. Some patients had arrangements with their pharmacists whereby they would bring in a prescription for government paid medicine and use it instead to pay for cosmetics of an equivalent value. The waste and red tape might be worth the price if they assured the best medical practice and health care. However, bureaucratic administration brought outrageous governmental interference that discouraged and handicapped medical men.

I came to the United States because I sought the opportunity to practice medicine in a way that I thought best for both doctor and patient — without regimentation, restrictions and interferences. I want only two people in the medical relationship — myself and my patient. There should be no impersonal governmental third party.

In this country I have found freedom of action and professional choice. Now I feel I am practicing in the best existing system in the world. It is not perfect. But we are striving to make it better. And the best medical care can be given only in the system where a doctor is not a government clerk but an individual with professional dignity and freedom.

Sesquicentennial Celebration Dates

SCIENTIFIC MEETING

May 8 and 9, 1962

Marvel Gymnasium, Brown University

DISTRICT MEDICAL SOCIETY MEETINGS

WOONSOCKET DISTRICT MEDICAL SOCIETY

The annual meeting of the Woonsocket District Medical Society was called to order on December 12, 1961, at 8:30 P.M. in the Woonsocket Hospital cafeteria by President Emil A. Kaskiw. Approximately 35 members were present.

A nominating committee was appointed consisting of Doctors Morrison, chairman, and A. King and Staudinger to select a slate of officers for the coming year. Their selection consisted of the following:

President ..... EUCLID L. TREMBLAY, M.D.
Vice-President ... ELPHEGE A. BEAUDREAULT, M.D.
Secretary ..... ALTON P. THOMAS, M.D.
Treasurer ..... PAUL E. BOUCHER, M.D.
Councillor ..... RICHARD H. DOWLING, M.D.
Delegates ..... DOCTORS WITTES, BLISS, MEDOFF
Censors DOCTORS MONTI, A. FONTAINE, MEDOFF

There being no other nominations, the secretary was directed to cast one vote for the incumbents. Elected.

Newly elected Doctor Tremblay presided for the rest of the meeting. Doctor Philip J. Morrison requested a show of hands to see how many doctors would like a dinner meeting next time with a speaker from Providence to talk on cancer research. Reaction was very favorable. The Cottage Club was selected by the society as being a good location for the affair, and a committee was appointed, headed by Doctor Morrison, to complete arrangements.

Doctor Tremblay called for a report from our representatives to the Rhode Island Medical Society but they were all absent. He next stated that he planned more social occasions for the coming year when the wives could be included. Reaction favorable.

Meeting adjourned 9:30 P.M. Refreshments.

ALTON P. THOMAS, M.D., *Secretary*

KENT COUNTY MEDICAL SOCIETY

At the annual meeting of the Kent County Medical Society the following officers were elected to serve in 1962:

GILBERT HOUSTON, M.D. ..... *President*
CHARLES B. ROUND, M.D. ..... *Vice President*
ROBERT F. CORRENTE, M.D. ..... *Secretary*
GEORGE B. FARRELL, M.D. ..... *Treasurer*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held on Monday, November 6, 1961, at the Medical Library of the Rhode Island Medical Society. The meeting was called to order by the president, Doctor Frank D. Fratantuono, at 8:30 P.M.

The minutes of the October meeting were not read, and Doctor Fratantuono stated that they would be published in the RHODE ISLAND MEDICAL JOURNAL.

The president called to the attention of the members the various meetings scheduled during November, including the New England Postgraduate Assembly at Boston, the Science Honors Lecture at Providence College, and the National Foundation Program to be held at the Medical Library. He also urged the members to support the dinner dance sponsored by the Woman's Auxiliary of the State Medical Society.

Doctor Fratantuono presented membership certificates to the physicians elected at the October meeting of the Association.

Scientific Program

The scientific program was a panel discussion on malpractice with the following discussors: Doctor Francis B. Sargent, chairman, Medical Defense and Grievance Committee and past president of the Rhode Island Medical Society; Mr. George E. Hall, legal counsel and secretary, Committee on Medicolegal Problems, the American Medical Association; Mr. Francis V. Reynolds, chairman, Grievance Committee, the Rhode Island Bar Association; and Mr. William B. Regan, legal counsel, Catholic Hospital Association of America, and editor and publisher, THE REGAN REPORT ON HOSPITAL LAW.

Doctor Sargent opened the discussion and reviewed the past seven and one-half years' experience with suits against Rhode Island doctors. During this period 39 were sued. No case that actually came to trial was lost by the physician. Some were settled out of court. There is no evidence in Rhode Island of the suit-prone doctor. No doctor was sued twice.

The reasons for malpractice suits are as follows:

1. An appetite for easy money on the part of the patient, stimulated by experience with automobile accidents or workmen's compensation.

2. High cost of medical care.
3. Loss of close doctor-patient relationship.
4. Large hospital bills.
5. Improper operation alleged.
6. Lack of informed consent by the patient.
7. Careless or damning notes in hospital records.
8. Telephone consultation.

Doctor Sargent concluded his remarks by advising doctors to:

1. Learn to spot a disgruntled patient.
2. Avoid criticism of a colleague.
3. Don't abandon a patient. Be sure to arrange adequate coverage if one is to be absent from his practice.
4. Keep good records and keep them long enough.
5. Provide adequate insurance coverage.
6. Notify Grievance Committee and Insurance Carrier promptly of threatened suit.

Mr. Hall reported that as a result of an A.M.A. poll one out of seven members have had a claim against them. Fifty per cent of the suits were against those in specialty practice representing 44 per cent of the physician population. Sixty-three per cent were the result of surgical mishaps chiefly revolving around poor results, foreign bodies and careless comment by a colleague.

A Connecticut study of 58 malpractice suits showed that 17 were first notified of suit by the plaintiff's attorney. Twenty-nine had no knowledge of suit until served a writ. Fifty-two of the 58 reported their practice unaffected by suit. One claimed injury for 1 year. Five said practice improved. None lost hospital privileges.

Has threat of suit affected medical practice? Fifty per cent of Massachusetts physicians answered in the affirmative giving the following results:

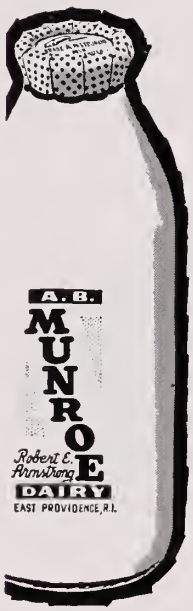
1. There is greater caution in case selection.
2. General practitioners limit their cases more.
3. It has led many to limit telephone advice.
4. There is increased use of laboratory and X-ray causing cost of medical care to rise.
5. There is increased consultation.
6. Greater care is taken to keep the patient informed.
7. It has caused greater care in the general conduct of medical practice.
8. Doctors fail to volunteer emergency care for fear of malpractice suit.

Mr. Reynolds re-emphasized some of the important points made by Doctor Sargent and Mr. Hall. He stated that whether a doctor is sued depends on how a person feels about doctors. If a doctor is sued he must prepare for trial very thoroughly and make it his personal responsibility to be in court every day.

concluded on next page

AS CLEAN
AS MODERN
DAIRY SCIENCE
CAN MAKE IT...





The A. B. Munroe Dairy Laboratory, where milk is subjected to constant testing, using the most modern methods of milk analysis.

Through every step in processing, from the immaculate receiving room to pasteurizing and homogenizing, on through bottling and refrigeration, the A. B. Munroe Dairy observes the strictest standards of dairy hygiene. The spotless surroundings and rigid quality control are so designed that all A. B. Munroe Dairy products that reach your table are as fresh, wholesome and pure as modern science can make them.



A. B. MUNROE DAIRY, INC.
151 Brow Street, East Providence, Rhode Island

Call GE 8-4450
for Home Delivery

Mr. Regan discussed the necessity for proper consent forms which should include admission of knowledge of the case and calculated risk. He recommended the A.M.A. consent forms which are available from the A.M.A. Medical records should be carefully prepared and policed. The attorney has to live with the record in defending a case. Medical Staff Bylaws should be up to date. A hospital bears the responsibility of providing adequate facilities and personnel for patient care and the physician bears responsibility to the hospital for proper conduct of his cases and preparing adequate records.

There was general discussion with audience participation.

The meeting adjourned at 10:40 P.M.

Collation was served.

Attendance was 170.

WASHINGTON COUNTY MEDICAL SOCIETY

The quarterly meeting of the Washington County Medical Society was held at the Doctors' Lounge in the Westerly Hospital on October 11, 1961.

The meeting was called to order at 11:17 A.M. by the president, Doctor James McGrath.

The minutes of the July, 1961, meeting were accepted as circulated to the membership without additions, corrections, or omissions.

The application of Doctor Jacob Pysariw as presented at the July, 1961, meeting was passed by the Board of Censors and the membership unanimously voted Doctor Pysariw into the Society.

Under unfinished business there was a short discussion of the investment plan as put forth by the Committee on Medical Economics. There is no further substantial information as yet.

The Sesquicentennial Exhibit was discussed. It was mentioned that each member of the Rhode Island Medical Society would be assessed twenty ($20.00) dollars to assist in meeting the expenses. Tickets will be necessary to gain admission to the exhibit.

The only communication was from the National Titanium Company who had some paint for sale.

Under new business three (3) new applications were considered. Since they were already approved by the Board of Censors they were presented to the assembled membership. All three were voted into the Society: Bohdan Kusma, M.D.; Hiram Kendall, M.D., and Francis Palaia, M.D.

There were no reports from the Standing Committees.

The business meeting adjourned at 11:39 A.M. and the meeting turned over to the guest speaker, Doctor Harold L. Beddoe, chief medical examiner for the State of Rhode Island, who attempted to explain the functions of his office in handling a coroner's case.

Respectfully submitted,
JOHN J. WALSH, M.D., *Secretary*



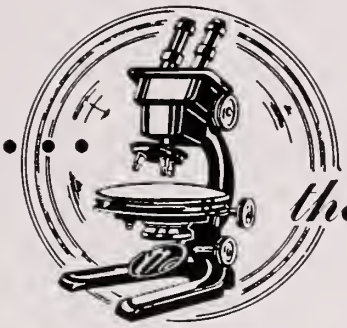
Wherever you go forget your telephone calls. We'll take them for you, day or night.

MEDICAL BUREAU

of the

Providence Medical Association

THROUGH . . . the Microscope



53 of Every 100 Men Over 65 Years Have Hospital Insurance

Men 65 years of age or older had some part of their hospital bill covered by insurance in 53 cases out of 100, according to a two-year study released in December by the U.S. Public Health Service.

For women in the same age range, the pattern was similar. Their hospital bills were partly covered in 49 cases out of 100.

The study covered the period 1958-1960 and was based on household interviews by the National Health Survey. It refers to persons discharged from short-stay hospitals who reported the proportion of their hospital bill paid by some insurance plan.

For men under 65, the study points out that some part of the bill was covered by insurance in at least 71 cases out of 100 and in some age groups this total rose to 76.

The estimates refer only to personal health insurance which was intended to pay hospital bills. They do not take account of other sources of payment for hospital bills such as disability insurance, liability insurance carried by someone other than the hospitalized person, the Veterans Administration, social security benefits, state and local governments, charitable organizations, or any other source of free care.

Preschool Project for Deviant Behavior

A new research and demonstration project involving children of preschool age who manifest deviant behavior is under way in Rhode Island. It is located on the grounds of Bradley Hospital but is a joint project of Bradley Hospital, Meeting Street School, and the Division of Maternal and Child Health of the State Department of Health, with major support from the Federal Children's Bureau. Diagnostic and treatment services are offered, although to a limited number of children because of the project's present small staff.

The project has progressed to the point where additional children may be accepted for diagnostic study. Practitioners are welcome to refer four-or-five-year-old children with deviant behavior to this project, and they will be accepted for study to the extent that the resources of the project allow and to the extent that they meet the project's requirement. Reports will be sent to the referring physician at the end of the study period of approximately three months. The service is on an out-patient basis entirely.

Physicians who are interested may contact Doctor Paoli at the Bradley Hospital, GEneva 4-3400.

"Bed-Disability Days" in U.S. Top Billion

In the course of a year, the employed population of the United States spent 265 million days in bed as a result of illness or injury, the Health Insurance Institute said recently.

This represents one quarter of the 1,054,800,000 "bed-disability days" suffered by the civilian noninstitutional population during the year ending June 1960, the Institute said. The information was based on an analysis of data from the U.S. National Health Survey.

The average worker had 4.3 days of bed disability per year, while the rate for men was 4.0 days and for women, 5.0.

The Institute said more than 42 million American workers are assured that their income will continue in the event they are disabled by off-the-job illness or injury.

As of the end of 1960, insurance companies protected 31,836,000 persons against the loss of income due to disability, and 10,600,000 workers were protected by other arrangements such as formal paid sick leave plans of federal, state and local governments; private industry; union plans, and employee mutual benefit associations.

The total of 42,436,000 persons so protected — representing 60 per cent of the civilian labor force — did not include the millions of other employees with some degree of income protection through informal wage-continuation practices, said the Institute. In addition, workmen's compensation provides wage replacement and medical care bene-

continued on next page

fits for workers who are disabled while on the job.

First 24 Hours of Life Most Dangerous

The first twenty-four hours of life are the most dangerous, according to a special report on the Newborn Infant by *Patterns of Disease*, a monthly Parke, Davis & Company publication for physicians. During the first day, according to *Patterns*, the mortality rate is 10.3 per 1,000 live births, dropping to 2.8 at one day, 1.8 the second day and 0.9 the third day.

The mortality rate of infants under 28 days of age is greater than the rate for infants 28 days to 11 months of age according to records for the ten-year period 1951 to 1960.

"Cautious Optimism" Voiced in Medical Education Report

The annual report on medical education of the American Medical Association expressed "cautious optimism" about the future supply of doctors and the facilities needed to train them.

The 1960-61 annual report, prepared by the A.M.A. Council on Medical Education and Hospitals, contained these encouraging developments:

— Plans for five new medical schools.

— An increase in enrollment in medical schools.

— Evidence that the quality of medical students has remained relatively constant since 1954.

— Indications for a future increase in medical school applicants.

— Stepped-up efforts to attract students into the medical profession.

— A trend toward relaxation of geographical restrictions on applicants to publicly owned medical schools.

— An increase in full-time faculty members in medical schools.

The Council said the establishment of new medical schools had been assured by five universities — Brown, Rutgers, Connecticut, New Mexico and Texas.

National Blood Serum Cholesterol Survey Planned

The measurement of serum cholesterol as presently practiced is admittedly unsatisfactory because of wide variations in results. This variability is attributable to the use of diverse methods, and to the unavailability of an acceptable universal standard.

The estimation of serum cholesterol, long used in the study of diabetes, nephritis and disorders of the liver, has become of added importance in recent years because of the relation of cholesterol metabolism to atherosclerosis and heart disease. The need for a procedure which will give reproducible results from place to place and from year to year is imperative.

It is the purpose of the Standards Committee of the College of American Pathologists to characterize a best cholesterol standard for universal use, and to recommend an analytical procedure which may serve as a consistent point of reference.

This national preliminary survey of serum cholesterol estimations is being organized to disclose the present status of this chemical procedure. All laboratory directors and pathologists in the United States will be invited to participate.

Inquiries may be addressed to Cholesterol Survey, College of American Pathologists, Prudential Plaza, Chicago 1, Illinois.

New Dean for Dartmouth Medical School

Doctor Gilbert Horton Mudge, professor and chairman of the Department of Pharmacology and Experimental Therapeutics and associate dean of the Johns Hopkins University School of Medicine, has been appointed dean of the Dartmouth Medical School.

Effective June 1, 1962, Doctor Mudge will succeed Dean S. Marsh Tenney who earlier announced his intention to relinquish the deanship in order to concentrate on his teaching and research as chairman and professor of physiology at the Dartmouth Medical School.

Doctor Mudge was graduated from Amherst College in 1936 and holds both the doctor of medicine and doctor of medical science degrees from Columbia University. He received his house officer's training as a physician at Presbyterian Hospital, New York. In World War II he served as a captain in the Army Medical Corps and as flight surgeon in the Ninth Air Force. From 1949 to 1955 Doctor Mudge was a member of the medical faculty of Columbia University; in 1955 he became professor of pharmacology and experimental therapeutics at the Johns Hopkins University School of Medicine and since 1960 he has also served the school as associate dean in charge of post-doctoral education.

At Dartmouth Doctor Mudge will hold appointment as professor of experimental therapeutics along with his deanship.

Safety Efforts Urged to Cut Accident Toll

Accidents kill more American children and young adults than all diseases combined, and one of the most important reasons are the misconceptions about safety held by many young people.

The Health Insurance Institute said recently that although the development of more and more safety devices has helped to reduce the number of accidents, more work needs to be done to improve individual knowledge, attitudes and habits concerning safety.

The Institute said the need for improved safety teaching for youngsters was indicated in a survey of some 5,000 school children published by the American Association for Health, Physical Education and Recreation. The survey showed the prevalence of health and safety misconceptions held by the children which included:

— Many thought that a bullet cannot go off unless it is fired by a gun; oil, grease and gas fires should be doused with water; if clothing catches fire, a person should always run for water; and bicycle riders do not have to obey traffic lights.

— About 75 per cent of the children thought the only good way to help a drowning person is to jump into the water to save him.

— Some 26 per cent of tenth graders thought it was all right to point a gun at someone if you are sure it is not loaded.

Safety Guides

The Institute said some valuable guides for helping children to live safely are included in a pamphlet prepared by the American Academy of Pediatrics, which said:

— Infants and preschool children should not be left unsupervised for even a short time for they are very susceptible to accidental injuries.

— Children are great imitators, and actions and attitudes of adults will be copied. It is not enough to tell a child to cross the street only when the light is green if the parent then crosses when the light is red.

— Excessive limitations of a child's activities may hinder the development of his ability to cope with dangerous situations.

— Minor accidents are to be expected during childhood; partially through them a child becomes aware of dangers.

Blood Bank-Transfusion Directory to be Published

Over 4,500 hospitals, Red Cross, and community blood banks are now being surveyed to determine and record their identities and relationship to transfusion services and blood banking. Specific data is being gathered to determine the number of units of human blood collected and transfused by each institution. This and other information will be published early in 1962 in a third edition of DIRECTORY OF BLOOD TRANSFUSION FACILITIES AND SERVICES by the Joint Blood Council.

The Directory will also include information on technical and operating procedures, approvals, supervision, reciprocity exchange systems, tissue storage banks, and other pertinent data. It carries also a coded functional definition for each listed facility.

Measles Vaccine Trials Get Under Way

Field trials for two types of measles vaccine got under way early in December in some 5,000 children beginning in five widely separate parts of the country, Surgeon General Luther L. Terry of the Public Health Service announced recently.

The studies are being conducted by local health departments, in co-operation with the Service's Communicable Disease Center, in DeKalb County, Georgia; Cincinnati, Ohio; Seattle, Washington; and in Rochester and Buffalo, New York.

"This is the first large scale trial of killed virus measles vaccine and the first time it has been used in combination with live virus vaccine in a field trial," Doctor Terry said. "The purpose is to find out how effective these methods will be in protecting children against measles."

Previous trials of measles vaccine, he explained, have tested the use of live vaccine alone or in combination with gamma globulin. The live vaccine alone has frequently produced fever and rash. These side effects are reduced when gamma globulin is used, but supplies of gamma globulin may not be adequate for mass vaccination programs since it is derived from human blood.

Doctor Terry pointed out that in the United States measles cause more deaths than any other common childhood disease. Conservative estimates indicate that approximately 500 children die each year as a result of infection with the measles virus. Many of these deaths are due to measles encephalitis which may occur as often as 1 in 400 cases.

The children in the current study will be divided into three groups. The first group will receive three shots of killed virus vaccine. The second will be given two shots of killed vaccine and one shot of live. The third will receive dummy injections (placebos).

Guide to Anticoagulant Therapy Issued for Physicians

A new booklet to provide physicians with guiding principles and practical recommendations for the use of anticoagulant drugs has been issued by the American Heart Association.

Titled *A Guide to Anticoagulant Therapy*, the booklet contains material designed to aid the physician who has decided to institute anticoagulant therapy in making the most effective use of these drugs. It does not consider the indications for therapy or the merits of different agents in the prophylaxis or treatment of specific diseases.

The two types of agents currently employed — heparin and coumarin-type compounds — are discussed with reference to their physiologic effects, administration, contraindications and appropriate antidotes. Fibrinolytic agents (either used alone or in combination with anticoagulants) are not included "because there has not been enough clinical experience to permit recommendations."

concluded on next page

The publication emphasizes the importance of individualized treatment, careful clinical observation, and frequent reliable laboratory tests. In addition, many common problems of anticoagulant therapy are discussed in question and answer form. The booklet also contains several tables and selected references.

The guide originally appeared as an article in the July, 1961, issue of *Circulation*, one of three professional journals issued by the Association. It was prepared for the organization's Committee on Professional Education by Benjamin Alexander, M.D., and Stanford Wessler, M.D., of Beth Israel Hospital, Boston.

Copies of the booklet may be obtained by physicians from the Rhode Island Heart Association.

Poison Prevention Week Scheduled for March

Representatives of 21 professional, industrial, and service organizations and federal agencies met at the Statler-Hilton Hotel in Washington, D.C., on November 21 to plan for the first National Poison Prevention Week, to be observed March 18-24, 1962.

A recent Act of Congress authorized the President to designate the third week of March each year as National Poison Prevention Week.

The meeting, called by the National Clearinghouse for Poison Control Centers of the U.S. Public Health Service and the American Pharmaceutical Association, selected children under five years of age as their prime target. Some 302,000 children under five suffer accidental poisoning every year.

A steering committee, composed of representatives of the two host organizations, the National Safety Council, the Food and Drug Administration, and the American Academy of Pediatrics, will co-ordinate activities for 1962 and generate plans for an even broader campaign in 1963.

Local Physician Wins TB and Health Association Grant

A grant for research on how the blood transports isoniazid, the principal drug used in treatment of tuberculosis, has been awarded to Doctor Ben C. Claunch, chief of the Tuberculosis Section of the Veterans Administration Hospital at Davis Park.

The $2,050 grant, financed through the annual state-wide Christmas Seal Campaign, is the first awarded for local research by the Rhode Island Tuberculosis and Health Association, Harry L. Gardner, president, announced. Such local grants usually are awarded only in localities which have a school of medicine.

Mr. Gardner said that the research can lead to more effective use of the drug in treating TB. The project has been approved by the committee on research of American Thoracic Society, the medical section of National Tuberculosis Association.

Doctor Claunch in explaining the project said:

"The proteins of the liquid portion of the blood are involved in the transport of many drugs, hormones, and vitamins. The degree to which binding of these substances occurs is known, in some instances, to affect the substances' availability to the body. Whether this union, or binding, occurs between isoniazid and the blood proteins has never been settled satisfactorily."

No previous work of this nature has been done utilizing living animals, nor has there been similar research done with quantities of the drug considered appropriate for clinical use.

Doctor Claunch hopes to determine whether one of the causes of the varying effectiveness of isoniazid treatment among individuals can be attributed to a chemical union of the drug and the blood which transports it to the seat of infection.

Molecular Biology Graduate Program Listed at Dartmouth

Dartmouth will inaugurate a new graduate program in the molecular biology area next fall that will lead to granting of the doctor of philosophy degree, President John Sloan Dickey announced recently.

The Dartmouth Medical School and college's Science Division will collaborate in this new program.

President Dickey said the program was made possible by the greatly expanded faculty and teaching and research facilities of the Medical School and the Science Division.

The program will consist of formal course work, seminars and tutorial sessions designed to provide a thorough grounding in the basic sciences that underlie present understanding of biological phenomena. In addition, it will stress familiarity with the current state of knowledge of biological processes and provide opportunities for work in modern research techniques.

DID YOU KNOW?

- That the Public Health Service has warned that the nation's battle against tuberculosis is showing signs of slowing down.
- That there were more than 55,000 new active cases of tuberculosis reported in 1960, a rate of almost 31 cases per 100,000 population.
- That, although this is a five per cent decline in the rates from 1959, the drop is not as great as that considered necessary to eliminate the disease as a major health problem.
- That authorities say, with presently available means of control, the annual rate of decline should be 10 per cent.

BOOK REVIEWS

FROM DEATH-CAMP TO EXISTENTIALISM. A Psychiatrist's Path to a New Therapy, by Viktor E. Frankl. Beacon Press, Inc., Boston, 1959. $3.00

"For ultimately, man should not ask himself, "what is the meaning of my life?", but should instead realize that it is not up to him to question — it is he who IS questioned, questioned by life; it is he who has to answer, by answering for life. His role is to respond — to be responsible."

This paragraph summarized the atmosphere of this remarkable book, the best of many I could quote. The reader should not shy away from the somewhat forbidding title. There are few of the usual "Death Camp" horrors and even less existentialist philosophy in this evening of reading (111 pages).

The author, now professor of psychiatry in Vienna, writes objectively of his own reactions and of those of others to the ultimate de-personalization and physical privation of a Nazi concentration camp. This is an account of the dulling of emotions by exposure and starvation, the concern with biological minutiae engendered thereby, and the sustaining mental images of loved ones and former experiences which saved many introspective men while their less imaginative but physically stronger fellow prisoners perished.

As a result of his experiences Doctor Frankl has evolved a concept of psychiatric help which he calls logotherapy, which is outlined in the second part of the book.

His general approach to therapy involves primarily a distinction made clear in his own words — "A doctor should never confuse that which is human with that which is pathological. . . .Man's will-to-meaning represents the most human phenomenon possible — and its frustration does not signify something pathological, at least not in itself. A person is not necessarily sick if he thinks that his existence is meaningless"; and also, "Parents and teachers, scientists and philosophers, have taught them all too long a time that man is 'nothing but' the resultant of a parallelogram of inner drives and outer forces. . . . I believe it to be a straight path from that homunculist image of man to the gas chambers of Auschwitz, Treblinka, and Maidanek."

This account shows by contrasts the extremes of behavior of "normal" humans, guards *versus* prisoners and prisoners *versus* prisoners. In a larger sense it points out more clearly than any account I have read, the emergence of warring factions in the human personality, the vile and the noble, the animal and spiritual, under conditions where it appears that each man must go one way or the other.

I heartily recommend this book for the study of all physicians. It is worth many times its weight in scientific publications.

JOHN D. PITTS

PATHOLOGY. Edited by W. A. D. Anderson, M.D. Fourth edition. The C. V. Mosby Co., St. Louis, 1961. $18.00

The fourth edition of this popular textbook of general pathology has been extensively revised and rewritten. The thirty-five contributors appear to have accomplished the purpose of the editor in presenting a thorough coverage of the subject in one volume. For practical and frequent use, however, the limit on size for one volume seems to have been reached. Its weight of 8.9 pounds exceeds that of the third edition by more than two pounds.

The subject material is arranged and written to serve as a comprehensive textbook for the medical student as well as a reference source for the pathologist or physician in practice. There is an orderly arrangement of the subject matter. Chapters on fundamental concepts of pathology are followed by chapters on the pathology of diseases produced by specific agents. The pathology of diseases and neoplasms of the various organ systems of the body is presented in the remaining chapters. The contributors have revised and rewritten their material to incorporate pertinent advancements in knowledge and new developments in the current literature.

A new type size and a new format improve the legibility of the pages. A detailed index, and the numerous references listed at the end of each chapter enhance the usefulness of the book. Ninety-one black and white illustrations and one color plate have been added.

Former chapters on general principles of resistance and infection, and on heredity and constitution in disease have been omitted. The revised chapter on bacterial diseases in the fourth edition includes a discussion of resistance and infection, but the subject of heredity and constitution is omitted

concluded on next page

LIFE INSURANCE or DEATH INSURANCE?

SOME Medical men need DEATH Insurance ONLY.

Others need accumulating, guaranteed dollar values to meet their LIVING needs in the future — DEPRESSION — EMERGENCY — RETIREMENT, etc.

In any event, our new "CHEAPER-THAN-TERM" DEATH INSURANCE is the first step in the right direction!

Don't make any important changes in your Life Insurance or Estate plans without investigating "CHEAPER-THAN-TERM"!

For further information about this sensational new development in DEATH INSURANCE, write or phone:

ROLAND A. DEROSIER
32 Custom House Street
Providence 3, Rhode Island
GA 1-1391

completely.

Two new chapters appear in this edition; one on hypersensitivity diseases and one on mesenchymal tumors. The chapter on hypersensitivity diseases is a concise presentation of the present concept of the antigen-antibody reaction followed by a description of the wide range of tissue responses by which the hypersensitivity reactions manifest themselves. In the chapter on mesenchymal tumors a practical method of classification of soft tissue tumors is outlined and descriptions are given of the most commonly encountered soft tissue tumors. Their microscopic appearance is well illustrated in the accompanying photomicrographs.

Among other revised chapters, the one on cells and their behavior has been rewritten completely to reflect the latest information about cell structure and function discovered by the use of new techniques in electron microscopy and cell fractionation. Also, the clinician and pathologist both will appreciate the new material in the chapter on disturbances of body water, electrolytes and circulation of blood.

Two chapters worthy of special comment in Anderson's *Pathology* are on subjects usually not covered in such detail in other textbooks of general pathology. In Moritz' chapter on physical agents in causation of injury and disease, and in Jetters' presentation on chemical injury there is valuable information on these subjects of increasing interest. Moritz has added a section on the medicolegal evidence to be sought in deaths from gunshot injuries. Jetter has expanded his general discussion on poisons, their definition, fundamental action, and the biochemical and pathologic changes due to poisons. New material of interest to the clinician includes the subject of drug hypersensitivity, clinical manifestations of poisoning, industrial poisons, diagnosis of poisoning, and methods for the collection of specimens for toxicological examination.

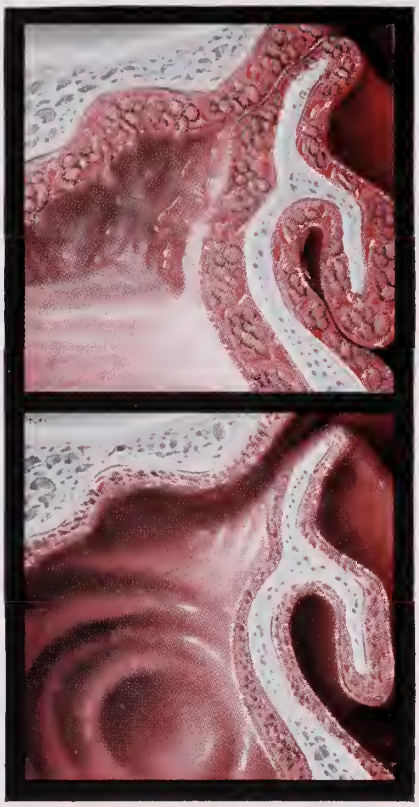
This book can be recommended as an excellent reference source and textbook of general pathology.

HAROLD L. BEDDOE, M.D.

INDEX OF ADVERTISERS

	PAGE
Ames Co.	19
E. P. Anthony	34
Armour Pharmaceutical Company	13
J. E. Brennan	50
Burroughs Wellcome	10-11
Curran & Burton	41
Derosier Agency	64
Endo Laboratories	47
Florida Citrus Commission	12
Fuller Memorial Sanitarium	50
Homeside Realty	Back Cover
Industrial National Bank	6
International Latex Co.	16-17
Lederle Laboratories	9, 15, 49
Thomas Leeming Co.	8
Eli Lilly & Co.	Front Cover
Medical Bureau	58
Medical Milk Commission	18
Munroe Dairy	57
Parke, Davis & Co.	Inside Front Cover and 1
Physicians Service	2
Sans Souci Hotel	34
G. D. Searle	20
Smith, Kline & French	4-5
E. R. Squibb	14
Wallace Laboratories	7
Warwick Club Beverages	41
Winthrop Laboratories	Third Cover

In colds and sinusitis unsurpassed in providing drainage space without chemical harm



The clogged sinus
In sinusitis, the mucous membrane becomes hyperemic and edematous, lymph glands and goblet cells hyperactive. Ostium is closed by edema and secretions cannot drain freely.

The normal sinus
Magnified anatomy of a portion of maxillary sinus showing mucous membrane with cilia and lymph glands. Ostium is normal and patent.

NEO-SYNEPHRINE®

brand of phenylephrine hydrochloride

hydrochloride

NASAL SPRAYS AND SOLUTIONS

When there is nasal turgescence, tiny orifices of sinus ostia tend to clog. Neo-Synephrine nasal solutions and sprays reduce edematous tissues on contact to provide prompt relief. As turbinates shrink, obstructed sinus ostia open, drainage and breathing become freer and the boggy feeling of a cold disappears.

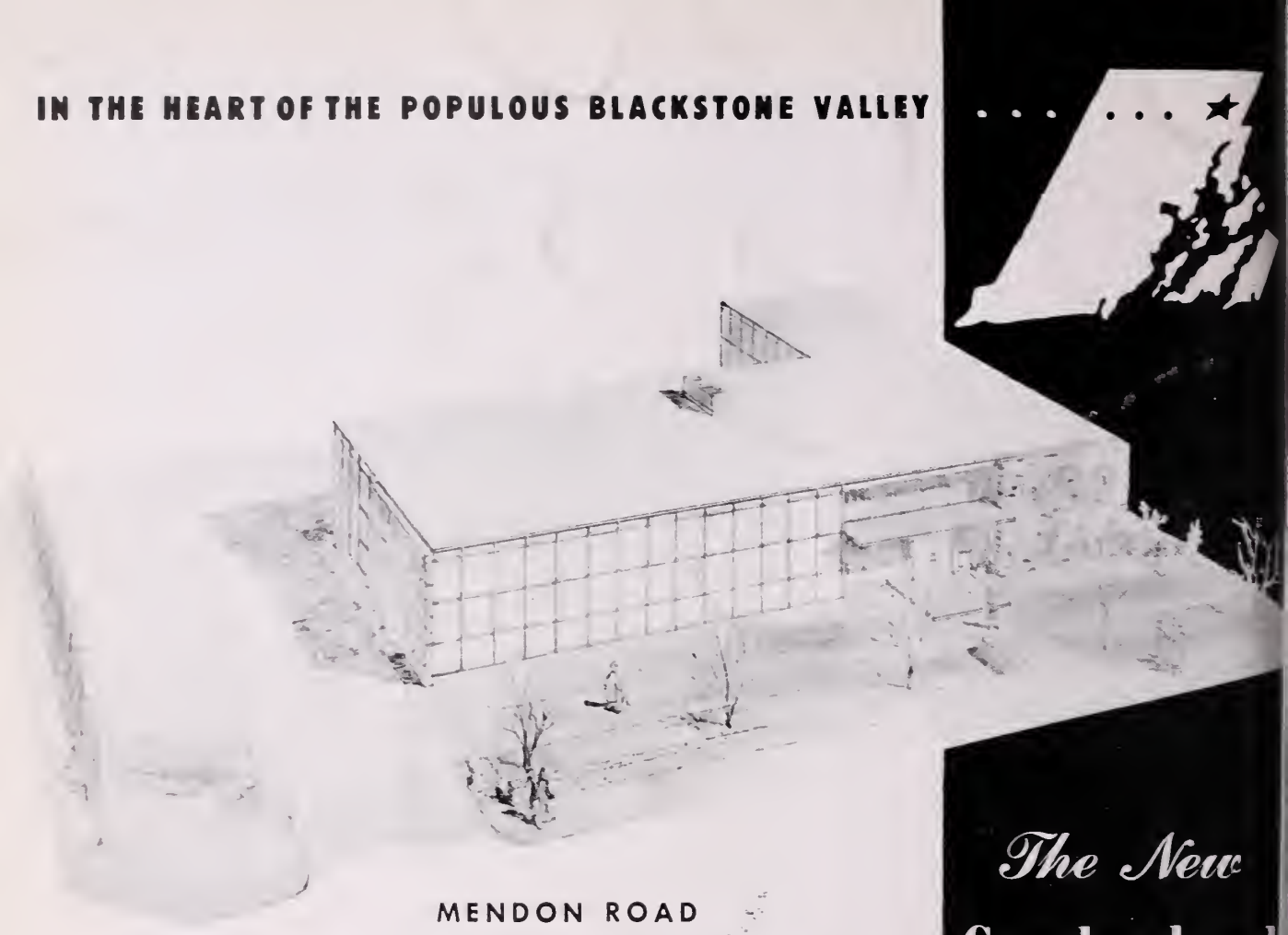
Delicate respiratory tissue and its natural defenses are not harmed by exceptionally bland Neo-Synephrine; systemic effects are nil; it does not sting. For years it has been recommended for prevention and treatment of sinusitis.[1-3] Repeated applications do not lessen effectiveness.

Available in plastic nasal sprays for adults (½%) and children (¼%), in dropper bottles of ⅛, ¼ or 1 per cent.

1. Grant, L. E.: Coryza and nasal sinus infections, **Clin. Med. & Surg.** 42:121, March, 1935. 2. Putney, F. J.: Sinus infection, in Conn, H. F. (Ed.): Current Therapy 1952, Philadelphia, W. B. Saunders Company, 1952, p. 110. 3. Simonton, K. M.: Current treatment of sinusitis, **Journal-Lancet** 79:535, Dec., 1959.

Winthrop LABORATORIES
New York 18, N.Y.

IN THE HEART OF THE POPULOUS BLACKSTONE VALLEY



MENDON ROAD

CUMBERLAND • RHODE ISLAND

On Route #126 near the Eddie Dowling Highway
– 20 minutes to downdown Providence

IN these days of an increasingly mobile population, the trend in business is to decentralize . . . to leave the congestion of urban areas that are being choked by traffic . . . and to turn that same traffic to advantage in the wide open spaces of suburbia.

This advantage also accrues to physicians and other professional men who, in ever increasing numbers, are relocating in suburban professional buildings.

The new Cumberland Medical Center will afford this basic advantage, plus several not enjoyed in such profusion in other areas.

Bomb shelter included in the building.

Suites will be available with areas of from 460 to 790 square feet, and will be partitioned to suit the needs of each tenant.

The New

Cumberland Medical Center

For Full Information
Phone
HOMESITE REALTY, Inc
Agents

PAwtucket 6-5100

FEBRUARY, 1962

RHODE ISLAND

Medical Journal

THE N Y ACADEMY OF MEDICINE
MAR -9 1962
LIBRARY

Sesquicentennial Meeting
May 8-9, 1962
Brown Gymnasium

Vol. XLV, No. 2
Table of Contents, page 67

Efficacy of propionyl erythromycin and its lauryl sulfate salt in 803 patients with common bacterial respiratory infections.

Tonsillitis* 92.3% 235 patients
Acute Streptococcus Pharyngitis* 88.3% 317 patients
Bronchitis* (Bacterial Complications) 95.3% 85 patients
Pneumonia* 88.6% 166 patients

*References available on request.

Ilosone® works to speed recovery

The usual dosage for infants and children under twenty-five pounds is 5 mg. per pound every six hours; for children twenty-five to fifty pounds, 125 mg. every six hours.

For adults and children over fifty pounds, the usual dosage is 250 mg. every six hours.

In more severe or deep-seated infections, these dosages may be doubled.

Available as: Pulvules®—125 and 250 mg.†; Oral Suspension—125 mg.† per 5-cc. teaspoonful; and Drops—5 mg.† per drop.

Lilly

This is a reminder advertisement. For adequate information for use, please consult manufacturer's literature. Eli Lilly and Company, Indianapolis 6, Indiana.
Ilosone® (erythromycin estolate, Lilly) (propionyl erythromycin ester lauryl sulfate)
†Base equivalent

232539

when urinary tract infections present a therapeutic challenge...

CHLOROMYCETIN®

(chloramphenicol, Parke-Davis)

Often recurrent... often resistant to treatment, urinary tract infections are among the most frequent and troublesome types of infections seen in clinical practice.[1,2] In such infections, successful therapy is usually dependent on identification and susceptibility testing of invading organisms, administration of appropriate antibacterial agents, and correction of obstruction or other underlying pathology.

Of these agents, one author reports: "Chloramphenicol still has the widest and most effective activity range against infections of the urinary tract. It is particularly useful against the coliform group, certain Proteus species, the micrococci and the enterococci."[1] CHLOROMYCETIN is of particular value in the management of urinary tract infections caused by *Escherichia coli* and *Aerobacter aerogenes*.[3] In addition to these clinical findings, the wide antibacterial range of CHLOROMYCETIN continues to be confirmed by recent *in vitro* studies.[4-6]

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100. See package insert for details of administration and dosage.

Warning: Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, granulocytopenia) are known to occur after the administration of chloramphenicol. Blood dyscrasias have occurred after both short-term and prolonged therapy with this drug. Bearing in mind the possibility that such reactions may occur, chloramphenicol should be used only for serious infections caused by organisms which are susceptible to its antibacterial effects. Chloramphenicol should not be used when other less potentially dangerous agents will be effective, or in the treatment of trivial infections, such as colds, influenza, or viral infections of the throat, or as a prophylactic agent. *Precautions:* It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

References: (1) Malone, F. J., Jr.: *Mil. Med.* **125**:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* **34**:187, 1959. (3) Ullman, A.: *Delaware M. J.* **32**:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* **108**:48, 1961. (5) Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: *Antibiotics & Chemother.* **10**: 694, 1960. (6) Lind, H. E.: *Am. J. Proctol.* **11**:392, 1960.

68961

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit 32, Michigan



Every addition to the family calls for Will review!

RHODE ISLAND
HOSPITAL TRUST
COMPANY

Births in the family can throw a Will out of kilter. So can other major family or property changes . . . marriages . . . inheritances . . . distribution of property . . . or new tax developments.

Take a fresh look at your Will, then talk with your attorney.



HOSPITAL TRUST

New England's Oldest Trust Company

OFFICES IN PROVIDENCE · CRANSTON · EAST PROVIDENCE · BRISTOL · EAST GREENWICH · NEWPORT · PAWTUCKET · WAKEFIELD · WOONSOCKET

The RHODE ISLAND MEDICAL JOURNAL

Editorial and Business Office: 106 Francis Street, Providence, R. I.

Editor-in-Chief: SEEBERT J. GOLDOWSKY, M.D.

Managing Editor: JOHN E. FARRELL, SC.D.

Senior Editors

ALEX M. BURGESS, SR., M.D. HENRI E. GAUTHIER, M.D.

Advisory Board

(in addition to editors listed above)

JOHN A. DILLON, M.D. JOHN F. W. GILMAN, M.D. ROBERT V. LEWIS, M.D.
PETER L. MATHIEU, M.D. JOSÉ M. RAMOS, M.D. ROBERT W. RIEMER, M.D.
JACK SAVRAN, M.D. LESTER L. VARGAS, M.D.

Owned and Published Monthly by
THE RHODE ISLAND MEDICAL SOCIETY
Second-class postage paid at Providence, Rhode Island
Copyright, 1962, the Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island
Single copies, 25 cents . . . Subscription, $2.00 per year.

Volume XLV, No. 2 February, 1962

TABLE OF CONTENTS

PAGE

CLOSED CHEST CARDIAC MASSAGE, *Robert L. Curran,* M.D.; *Joseph R. Gaeta,* M.D.; *Frank Merlino,* M.D., AND *Lester L. Vargas,* M.D. 85

INTERCOSTAL PHENOL NERVE BLOCK, *Edward Damarjian,* M.D. 89

THE MILK-ALKALI SYNDROME, With Report of a Case, *Johannes Virks,* M.D., AND *Ezra Sharp,* M.D. 91

REFLECTIONS ON THE KING-ANDERSON BILL (H.R. 4222) Part II, *Reverend Stanley Parry,* C.S.C., PH.D. 98

EXTRA-UTERINE (ABDOMINAL) TERM PREGNANCY, A Case Report, *Henry E. Turner,* M.D. 108

MENINGIOMA WITH BONE DESTRUCTION, *José M. Ramos,* M.D., AND *Donald B. Fletcher,* M.D. 110

A STUDY OF SURGERY, UROLOGY AND PROCTOLOGY 112

EDITORIALS

The Health Fair 103

Happy Birthday! 103

Stanley H. Saunders 104

Means Test Poppycock 105

A Valuable Property 105

DEPARTMENTS

Book Reviews 72

Cancer Symposium Program 102

Through the Microscope 116



AVAILABLE IN 2 POTENCIES:

MILPATH-400—Yellow, scored tablets of 400 mg. Miltown (meprobamate) and 25 mg. tridihexethyl chloride. Bottle of 50. *Dosage:* 1 tablet t.i.d. at mealtime and 2 at bedtime.

MILPATH-200—Yellow, coated tablets of 200 mg. Miltown (meprobamate) and 25 mg. tridihexethyl chloride. Bottle of 50. *Dosage:* 1 or 2 tablets t.i.d. at mealtime and 2 at bedtime.

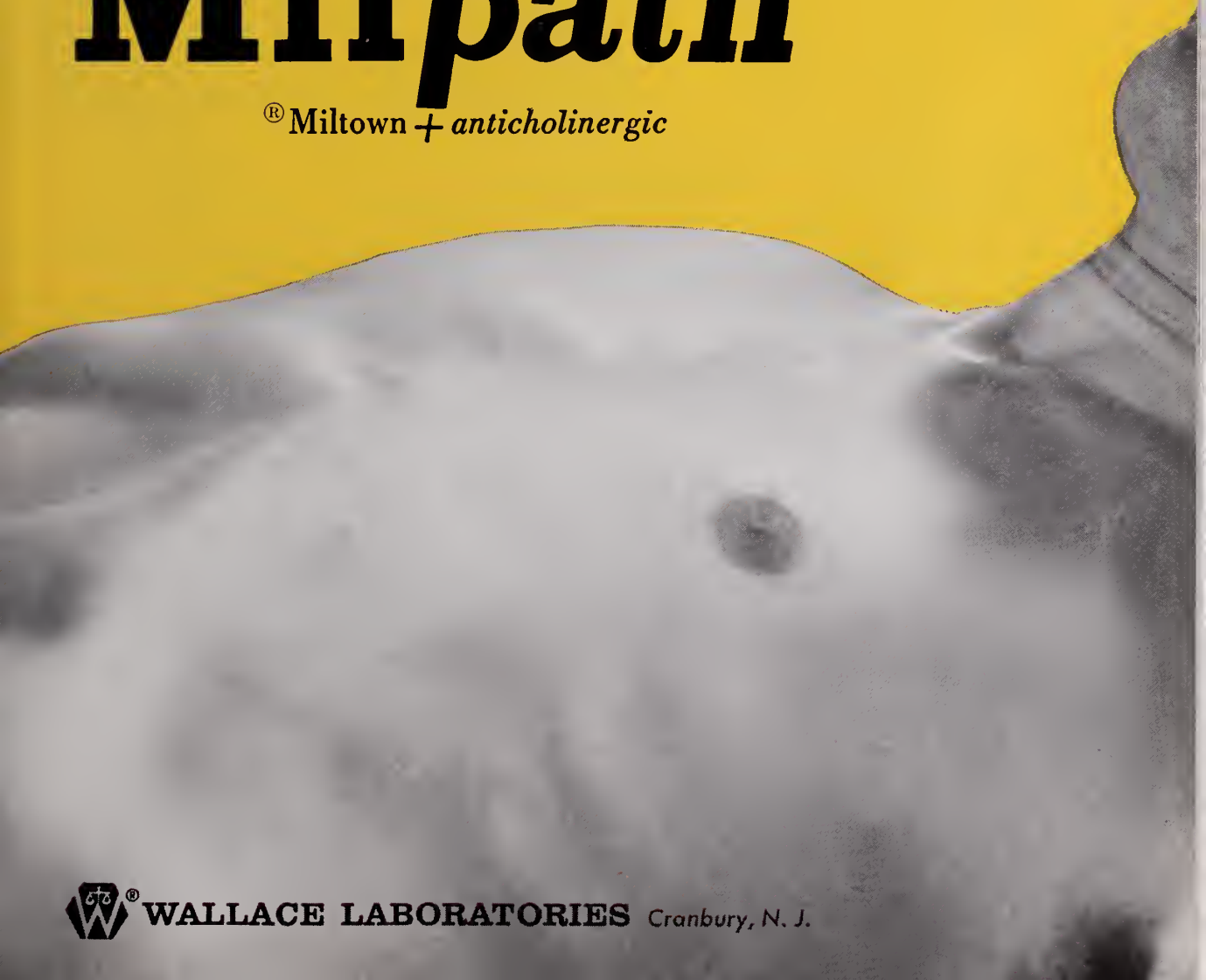
IN GASTROINTESTINAL DYSFUNCTION

Milpath helps you provide care of the man, rather than merely his stomach:

acts quickly to suppress hypermotility, hypersecretion, spasm and pain . . . alleviate anxiety and tension with minimal side effects.

Milpath®

®Miltown + *anticholinergic*

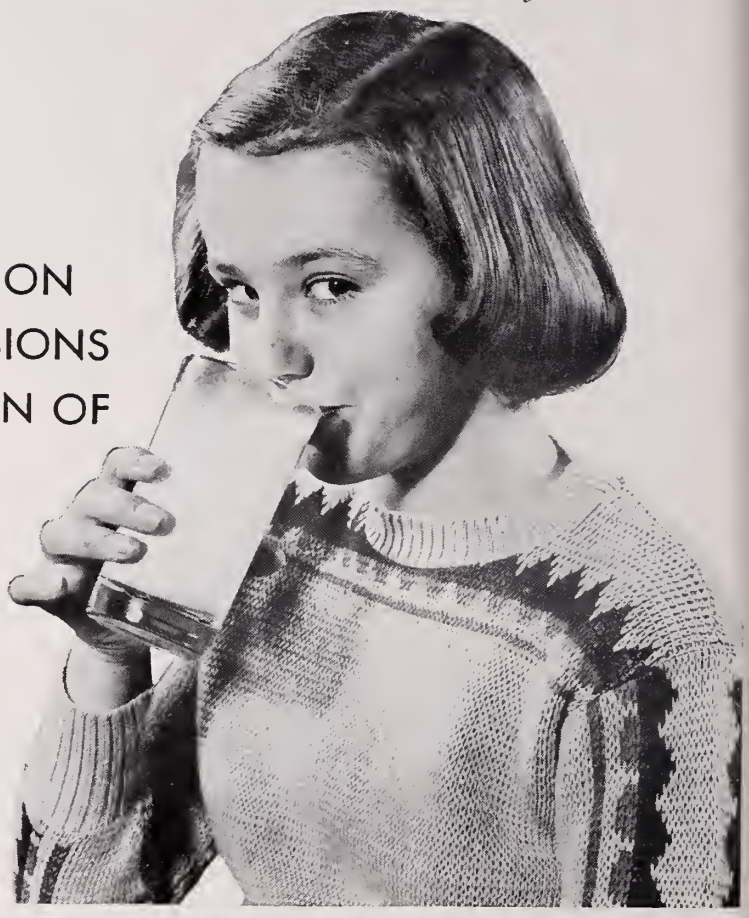


WALLACE LABORATORIES Cranbury, N. J.

Certified MILK

THE AMERICAN ASSOCIATION OF MEDICAL MILK COMMISSIONS SUPERVISES THE PRODUCTION OF

Certified MILK



1. CLEANER. Lowest bacteria-count. Milk checked before each milking. All utensils, bottles, and equipment sterilized before use.

2. BETTER-PROTECTED. Strictest medical supervision of herds and employees. Frequent examinations and laboratory-control AT THE FARM are required.

3. AUTOMATIC MILKING. Cows are milked automatically by electric machine. Milk is bottled without exposure to air or human touch.

4. BOTTLE CLOSURES. Must be of the highest quality to provide complete protection for the milk and bear approval of The American Association of Medical Milk Commissions.

5. MORE NUTRITIOUS. Cows scientifically fed balanced ration. Nutrition control from soil to delivery of milk. Same diet all year.

6. LONGER-LASTING, BETTER-TASTING. Diet control, special handling, and shortest time of delivery from cow to consumer assure fine fresh flavor that lasts for weeks.

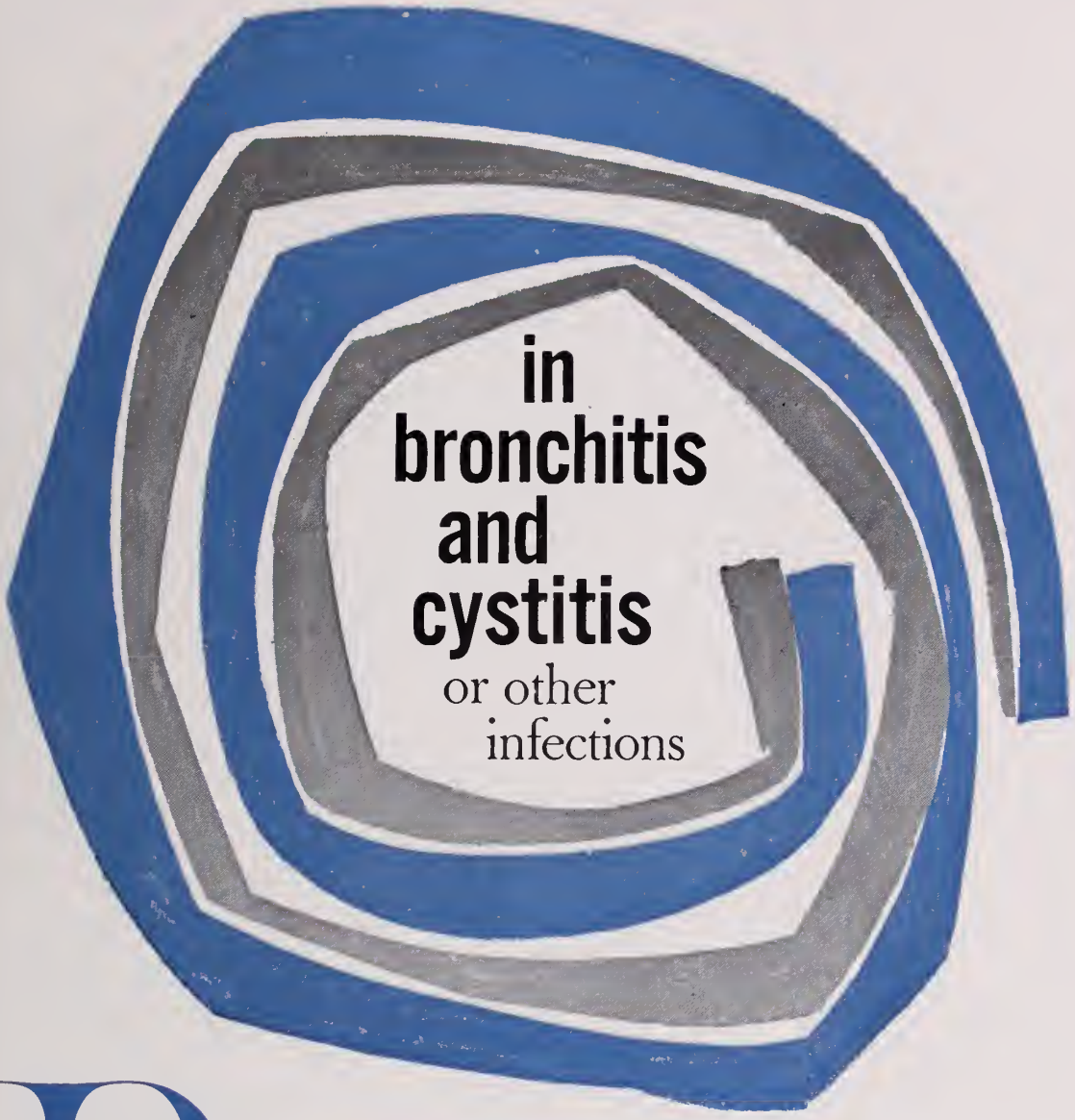
7. THE DOCTOR'S MILK. Produced, processed, bottled on farms supervised by Medical Milk Commissions. Each bottle bears the seal of the A.A.M.M.C. and names of the supervising Commission and producing farm.

MILK COMMISSION OF PROVIDENCE MEDICAL ASSOCIATION

HILLSIDE FARMS, INC., 1308 Phenix Ave., Cranston, WI 2-3400
Produced at Hillside Farm, Cranston, R. I.

H. P. HOOD & SONS, 135 Harris Ave., Providence, DE 1-3024
Produced at Hood Certified Farm, Beverly, Mass.

WHITING MILK CO., 40 Tockwotton St., Providence, GA 1-5363
Produced at Hampshire Hills Farm, Wilton, N. H.



antibiotic therapy with an added measure of protection

DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE LEDERLE

against relapse—up to 6 days' activity on 4 days' dosage
against secondary infection—sustained high activity levels
against "problem" pathogens—positive broad-spectrum antibiosis

CAPSULES, 150 mg., 75 mg. — PEDIATRIC DROPS, 60 mg./cc. — SYRUP, 75 mg./5 cc.

Request complete information on indications, dosage, precautions and contraindications from your Lederle representative or write to Medical Advisory Department.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

BOOK REVIEWS

PROBLEMS IN SURGERY. From Surgical Grand Rounds at the New York Hospital-Cornell Medical Center by Frank Glenn, M.D. Edited by George E. Wantz, Jr., M.D. The C. V. Mosby Co., St. Louis, 1961. $16.50

PROBLEMS IN SURGERY consists of a collection of cases which were presented at Grand Rounds of the Department of Surgery at the New York Hospital-Cornell Medical Center. The several chapters in the volume are divided into problems in pulmonary surgery, cardiac surgery, surgery of the alimentary tract, biliary tract, and endocrine glands. In addition there are chapters on problems in urologic surgery, neurosurgery, plastic surgery, fractures and dislocations, and orthopedic surgery.

Each of the presentations is short, averaging 2 to 3 pages, and the material within each consists of a brief case presentation followed by a discussion of the problem by members of the New York Hospital Surgical Staff and guests. At the conclusion of each case there is a short paragraph regarding the decision and outcome of the specific problem. A few selected references are appended.

Since the book, therefore, consists of a large number of diverse problems and unusual cases, it offers an interesting and educational evening to the general surgeon who has maintained his curiosity regarding surgical problems in his own type of practice as well as those not specifically related to his own field. Beyond this I do not feel that the book serves any specific function. It certainly does not offer a complete discussion of any of the surgical problems which it explores, nor do the authors claim to do this. The collection might be of value to surgical residents for whom the initial conferences were primarily aimed, but even for this type of reader the benefit would be the occasional "pearl," rather than a comprehensive understanding of the problem at hand.

It has been repeatedly stated that we are presently overwhelmed by a huge torrent of printed material which must be evaluated and digested, and that much of this material is, in fact, extraneous. I feel that PROBLEMS IN SURGERY is an example of such an unnecessary book. While the individual cases were probably fascinating and highly instructive to the people involved in these Grand Rounds, in book form they lose much of their spontaneity and freshness. I feel that there is no need for the immortalization of such conferences, and most especially feel that there is no indication for preserving them in a volume which is marketed for $16.50.

Perhaps the greatest benefit that one can derive from reading this book is once again to become aware of the fact that the thought processes of the occupants of the ivory towers of medicine are often identical to our own, and furthermore that a problem in Providence is often also a problem in New York.

BANICE M. WEBBER, M.D.

INTRODUCTION TO ANESTHESIA. The Principles of Safe Practice by Robert D. Dripps, M.D.; James E. Eckenhoff, M.D., and Leroy D. Vandam, M.D. Second edition. W. B. Saunders Company, 1961. $8.00

This second edition of INTRODUCTION TO ANESTHESIA has been expanded to include such timely subjects as hypothermia, mechanical ventilation, hypnosis, controlled hypotension, cardiopulmonary by-pass, and many others. The authors have shown considerable skill in the arrangement and presentation of the numerous topics that are so essential to the student anesthetist. Several chapters should prove to be of interest to nurses and physicians, who care for patients in recovery rooms and intensive care units. The material on circulation, respiration, and resuscitation is pertinent to understanding the problems that arise in the care of these individuals.

H. W. UMSTEAD, M.D.

WHAT TEENAGERS WANT TO KNOW by Florence Levinsohn, B.A., M.A., in consultation with G. Lombard Kelly, A.B., B.S.M., M.D. Budlong Press Co., Chicago, 1961. $1.50

This is an 89-page booklet which purports to give teenagers "all the answers" and pretty well lives up to this aim. One might wish that it had been published in two sections; one for boys and one for girls.

It should be read in its entirety only by teenagers of the age of high school seniors or college students but should not be passed out promiscuously or used as a class textbook.

Adults who deal with young people would find

continued on page 76

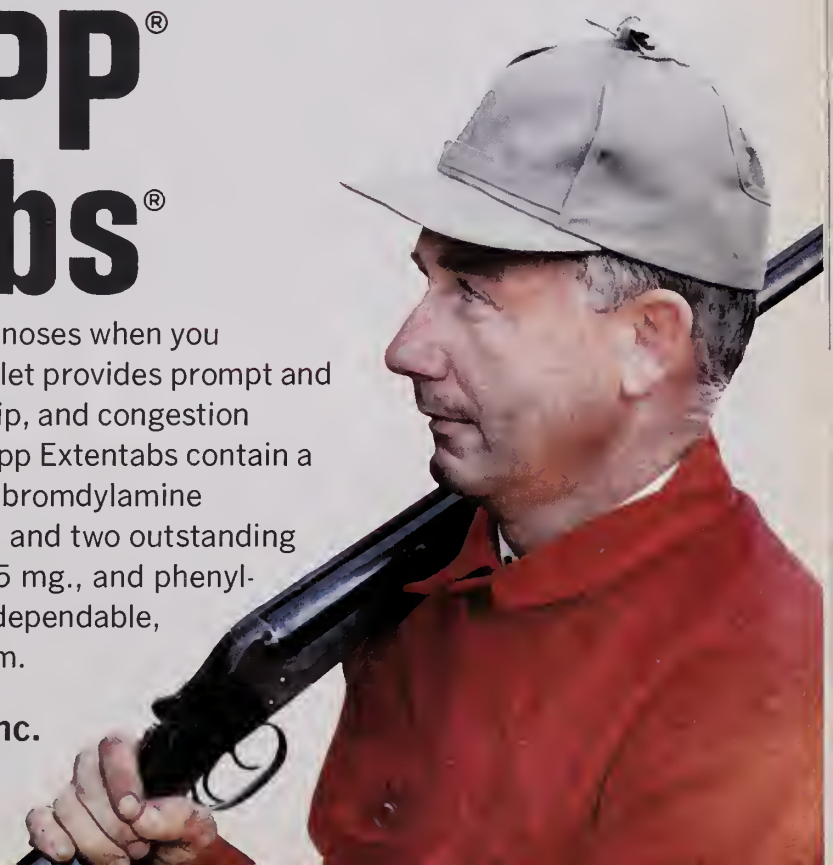


OPEN SEASON ON CLOGGED NOSES

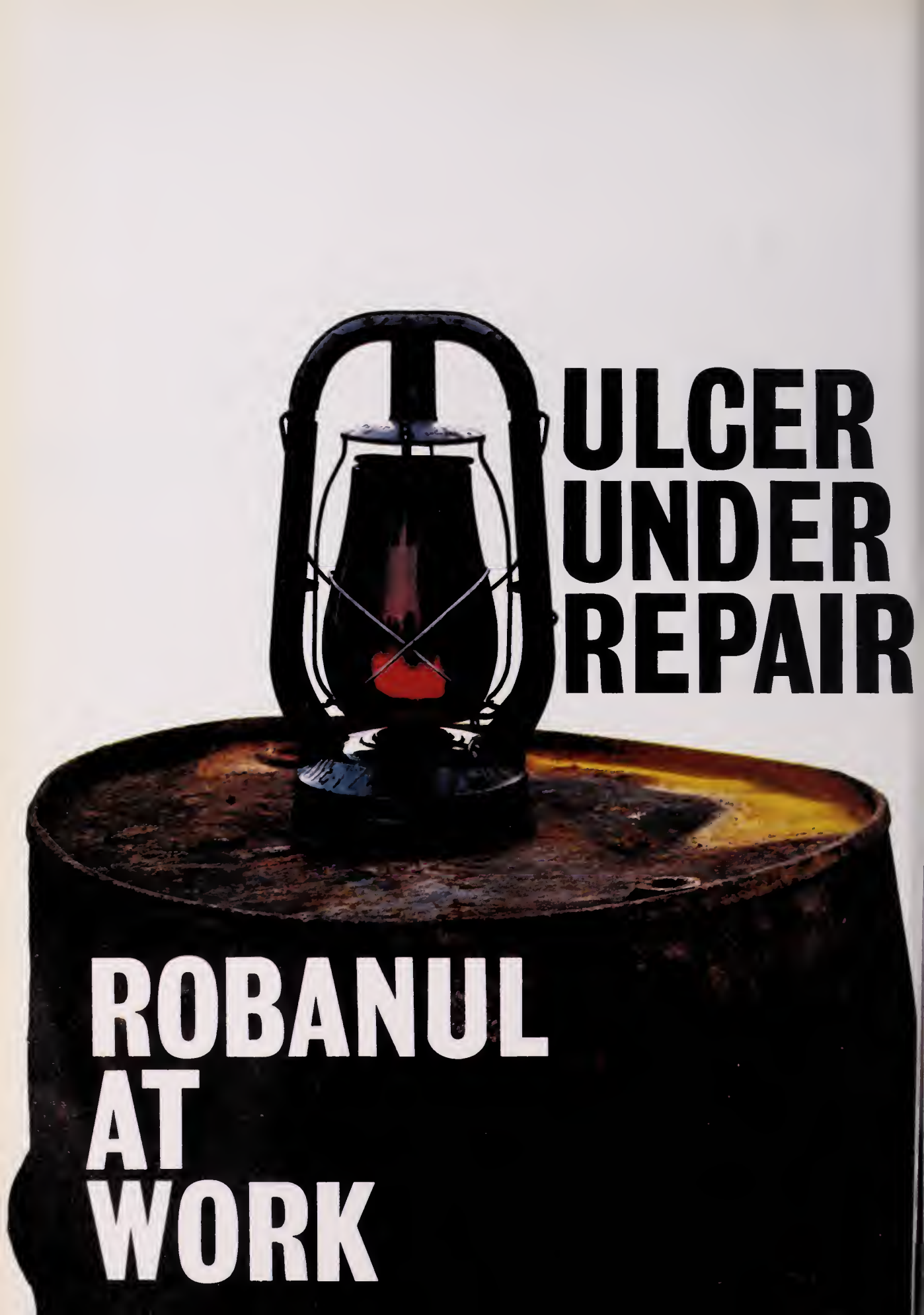
in sinusitis, colds, U.R.I.,
10-12 hours
clear breathing on 1 tablet

DIMETAPP® Extentabs®

It's always Open Season on stopped-up noses when you prescribe Dimetapp Extentabs. One tablet provides prompt and prolonged relief from the stuffiness, drip, and congestion of upper respiratory infections. Dimetapp Extentabs contain a proven antihistamine, Dimetane® [parabromdylamine (brompheniramine) maleate]—12 mg., and two outstanding decongestants, phenylephrine HCl—15 mg., and phenylpropanolamine HCl—15 mg.... all in dependable, long-acting (10-12 hours) Extentab form.



A. H. Robins Company, Inc.
Richmond, Va.


ULCER
UNDER
REPAIR
ROBANUL
AT
WORK

New

Robanul™ signals a major improvement in duodenal ulcer therapy

From Robins research comes Robanul (generically, Glycopyrrolate), first of the "rigid-ring" anticholinergics, representing what may well be the most important advance in anticholinergic chemistry in a decade.

Clinically, both Robanul and Robanul-PH (with phenobarbital) have demonstrated a remarkable ability to provide within 90 minutes—and maintain for 6 to 10 hours—those nearly ideal pharmacologic healing conditions that mean prompt relief of ulcer pain and a successful recovery of your ulcer patient.

There are always important questions about any new therapeutic agent. Below are answers to some of the common ones asked about Robanul:

ROBANUL™

Glycopyrrolate (Robins), 1.0 mg. per tablet (U.S. Pat. No. 2,956,062)

ROBANUL™-PH

Robanul with phenobarbital, 16.2 mg. per tablet

First of all, what does "rigid-ring" mean?

Briefly, this: it describes the use of a fixed pyrrolidine pentagon, or rigid ring, which guarantees a constant 2-carbon distance between reactive parts of the molecule. In line with the "receptor site" concept of the mechanism of action of anticholinergics, this almost inflexible molecule is theoretically more likely to "fit" only certain receptor sites.

Theories are all right, but is Robanul really more selective?

Yes! Evidence of its selectivity can be seen by the surprising lack of typical secondary anticholinergic effects (dry mouth, blurred vision, etc.) that occur at the effective dosage level of 1 to 4 mg. a day. Out of 499 duodenal and gastric ulcer patients treated at this level in investigative studies, only 4.4% had complaints of moderate to severe effects.

How is it for reducing gastric acid?

One investigator[1a] found that a 2 mg. dose of Robanul lowered acid secretion 73% in one hour (compared to a basal-hour period) and 84% in two. A 4 mg. dose dropped secretion over 94% in one hour and 97% in two!

What about acidity, or concentration of acid?

In one study, glycopyrrolate produced significant suppression of pH to 4.5 or higher in 5 of 5 duodenal ulcer patients given a 4 mg. dose, 7 of 8 patients given 2 mg., and 4 of 5 patients given 1 mg.[1b]

Will Robanul depress gastric hypermotility?

In another study[2] with six subjects Robanul decreased gastric motility in every patient. Within 40 minutes after the administration of 2 mg. of Robanul, the frequency of gastric antral contractions decreased from 1 every 24 seconds to only 1 every 2½ minutes. Young and Sun[1c] found a similar effect. Moreover, their results in 7 patients indicated that Robanul, in a dose of 2 mg., did not produce delay in gastric emptying or intestinal transit.

What's the best dosage schedule for Robanul?

It should be adjusted for each patient, and this is where Robanul offers another big advantage. Its "titratability" is unmatched among anticholinergic agents. Robanul's potency makes possible a recommended starting dose of only one milligram t.i.d. Yet its selectivity usually permits much leeway for dosage adjustment upward as necessary, to achieve the most effective dose level for each patient while maintaining a low incidence of undesirable effects on other organ systems.

Is there anything else Robanul does for peptic ulcer?

Much more! For instance, 2 mg. cuts pepsin production about 50% in two hours; 4 mg., about 65%.[1a]...There is evidence that Robanul combats hormonal aspects of gastric secretions as well as vagal in many patients... ...Its activity lasts long enough to reduce acid secretion all night long.[3]...Many ulcer patients have remarked about its fast relief of pain....

One last question: Why not prescribe Robanul for your next duodenal ulcer patient and see for yourself just exactly how effective it is?

References: 1. From the New York Academy of Sciences, Conference on Peptic Ulcer, Oct., 1961. (a) H. C. Moeller. (b) D. C. H. Sun. (c) R. Young and D. C. H. Sun. **2.** W. C. Breidenbach: Investigative clinical report, March, 1961. **3.** I. A. Feder: Investigative clinical report, May, 1961.

Additional information upon request.

A. H. Robins Company, Inc., Richmond 20, Va.

PHARMACEUTICALS RESEARCH

"The first prescription I ever wrote was for 'Empirin' with Codeine...



and it is still my stand-by for pain relief today."

PICTURE THE YOUNG DOCTOR with his first private patient, about thirty-five years ago. This is the moment, after years of study and guidance in classroom and at hospital bedside, when he assumes the full weight of responsibility for the well-being of his patient. He makes his diagnosis. The patient is in considerable pain, and his first concern is to relieve this discomfort. He writes a prescription for a new analgesic, a convenient drug combination that he believes will be of help. This patient (and many others to follow) finds gratifying relief, and the physician continues to rely upon this medication as the years go by.

Could this have been you in the 1920's? That was when 'Empirin' Compound with Codeine first came into general use (although plain 'Empirin' Compound has been well-known since the influenza epidemic of 1918). Satisfaction through the years has prompted doctors everywhere to depend on 'Empirin' with Codeine for relief of most all degrees of pain. For with this well-tolerated, reliable analgesic combination you can be sure of results, and feel secure in the fact that the liability of addiction is negligible.

Please accept our thanks for continuing to place your trust in a product that has been used more widely in medicine each year for the past four decades.

'EMPIRIN' COMPOUND with CODEINE PHOSPHATE*

Acetophenetidin, gr. 2½
Acetylsalicylic Acid, gr. 3½
Caffeine, gr. ½

Remember there are now four strengths available...

*Warning—May be habit-forming.
Subject to Federal Narcotic Regulations.

No. 1 — gr. ⅛
No. 2 — gr. ¼
No. 3 — gr. ½
No. 4 — gr. 1

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

BOOK REVIEWS

continued from page 72

this book useful in getting ideas for ways of telling them what they want to know about growing up, sex problems, and dealing with their families. The adult could then decide what information to pass along, depending on the maturity of the individual boy or girl.

It would be a good book for study by a P.T.A. study group. Any parent of teenage children would find it very helpful.

AMY E. RUSSELL, M.D.

OBSTETRICS. From the Original Text of Joseph B. DeLee, M.D., by J. P. Greenhill. W. B. Saunders Co., Phil., 1960. 12th ed. $17.00

This is the twelfth edition of Doctor Lee's textbook. The last five editions have been re-edited and rewritten by Doctor Greenhill.

The general organization of the material in this text has been preserved, but several new chapters have been added and extensive rewriting has been done by Doctor Greenhill to include recent advances in knowledge and current concepts.

There are many chapters dealing with specialized topics relating to obstetrics and the basic sciences which have been written by medical authors distinguished in their respective fields. An unusual chapter dealing with the physiology of the fetus and newborn is composed for the most part of excerpts from Doctor Clement Smith's *Physiology of the Newborn Infant*.

This obstetrical text will be a useful source of basic obstetrical information for the medical student, and yet serve as an excellent reference source to the practitioner in reviewing current concepts in the fields of physio-pathology, endocrinology, and therapeutics.

Doctor Greenhill's vast knowledge of the current obstetrical and gynecological literature, gained as editor of the YEAR BOOK OF OBSTETRICS AND GYNECOLOGY, is reflected throughout his text.

BERTRAM H. BUXTON, JR., M.D.

THE QUESTION OF FERTILITY by Georges Valensin, M.D. Translated from the French by Leah Suchodolski. Doubleday & Co., Inc., Garden City, N.Y., 1960. $4.50

This book is primarily geared for consumption by the lay reader, but many sections will evoke the interest of the scientific reader and the clinician.

The book deals with the broad aspects of fertility, in general, including its control. In particular, it discusses the current knowledge, practice and history of artificial insemination both by homologous (A.I.H.) and donor (A.I.D.) method.

A fascinating opening chapter introduces the reader to the varied and intriguing practices in nature of fertilization in both animal and plant life. The author makes numerous references to the results of research in the field of cattle and horse breeding particularly. These studies relate to the collection and preservation of semen. The chapter dealing with the hygiene of reproduction is weakly supported, in many cases, by impressionistic and controversial statements, but do reflect the author's robust, healthy, sincere, and natural approach to human sexual behavior. The chapters that follow deal mainly with homologous and donor insemination. There is, in general, a less than thorough presentation of the specific indications for donor selection, technics, and the legal and religious attitudes involved.

The final chapters on the future uses of insemination and the potential areas of success in dealing with the disordered reproductive system reflect the author's fertility of imagination and often seem the result of deliberate fantasy.

The book has been translated from the original French manuscript and the translator, Leah Suchodolski, has, in general, skillfully preserved the style, meaning, and wit of the author. Only occasionally will complex sentence structure disturb the reader. Some of the descriptive passages are delightfully expressed and are reminiscent of those one might find in THE ONE THOUSAND AND ONE NIGHTS. Most readers will not be resentful of the usually good-humored satire directed here and there at the various institutions of our civilized culture.

The title seems a bit ambiguous, at first, but is probably the result of a compromise by the American publishers who considered it less controversial than the original French title, *La Fecundation Artificielle et Naturelle de la Femme*. Certainly much of this book will be enjoyed by anyone interested in the field of reproduction regardless of his basic scientific, philosophic or religious background.

BERTRAM H. BUXTON, JR., M.D.

RESPIRATION IN HEALTH AND DISEASE by R. M. Cherniack, M.D., and L. Cherniack, M.D. Illustrated by Nancy Joy, A.O.C.A. W. B. Saunders Co., Phil., 1961. $10.50

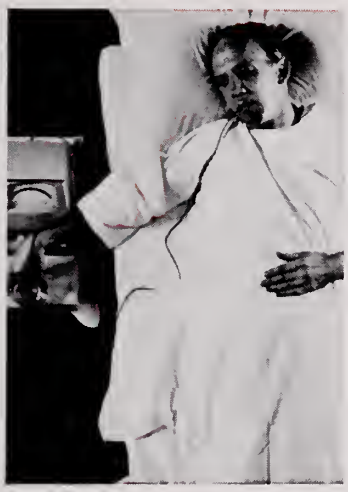
The authors are brothers and both have had considerable experience in respiration investigations. The book tries to analyze the mechanism of the diseases instead of describing them. To this end, the book is divided into four sections.

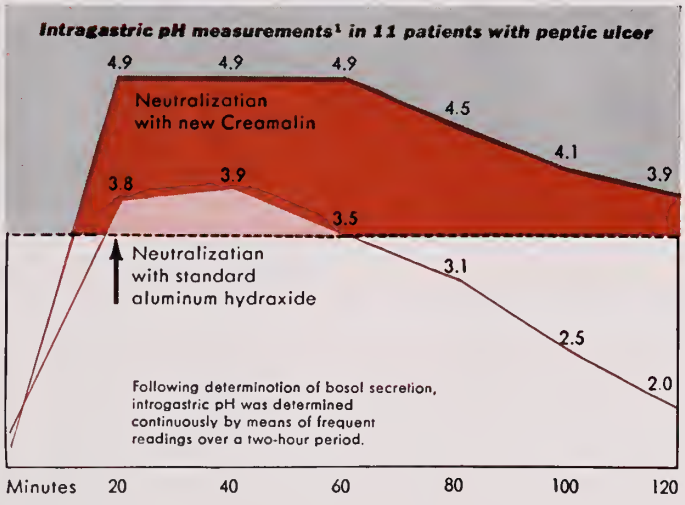
The first section deals with the mechanics of breathing, distribution of gas and blood and gaseous exchange, the regulation function of the blood, and the regulation of respiration. This section of

concluded on page 78

Acts as well in people as in test tubes

in vivo
neutralizes
40 to 50 per cent
faster—
twice as long at
pH 3.5 or above





New Creamalin®

Antacid Tablets

Buffers fast[1-4] for fast relief of pain—
takes up more acid

Heals ulcer fast—action more prolonged *in vivo*

Has superior action of a liquid, with the convenience of a tablet[5]

Each new Creamalin antacid tablet contains 320 mg. of specially processed, highly reactive dried aluminum hydroxide gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. New Creamalin tablets are pleasant tasting and smooth, not gritty. They do not cause constipation or electrolyte disturbance.

Dosage: Gastric hyperacidity—from 2 to 4 tablets as needed. Peptic ulcer or gastritis—from 2 to 4 tablets every two to four hours.

How Supplied: Creamalin Tablets, bottles of 50, 100, 200 and 1000. Also available: New Creamalin Liquid (1 teaspoon=1 tablet), bottles of 8 and 16 fl. oz.

References: **1.** Schwartz, I. R.: *Current Therap. Res.* 3:29, Feb., 1961. **2.** Beekman, S. M.: *J. Am. Pharm. A.* (Scient. Ed.) 49:191, April, 1960. **3.** Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:381, July, 1959. **4.** Data in the files of the Department of Medical Research, Winthrop Laboratories. **5.** Hinkel, E. T., Jr. ; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:384, July, 1959.

Winthrop LABORATORIES
New York 18, N.Y.

FOR PEPTIC ULCER • GASTRITIS • GASTRIC HYPERACIDITY

BOOK REVIEWS

concluded from page 76

the book seems of particular usefulness to those interested in the now expanded and new field of pulmonary physiology. The remaining sections deal with the manifestations of respiratory diseases; and symptoms such as cough, dyspnea, and the signs of inadequate gaseous exchange are well defined and discussed. In the section on the pattern of respiratory disease, the chapter on cardio-respiratory insufficiency, in my opinion, is well written and clearly outlined. In the last section, dealing with the assessment of respiratory disease, the clinical, radiological, and functional considerations which should be made in any case with pulmonary pathology are well treated and discussed for a pointed diagnosis of pulmonary dysfunction.

The book does not contain a bibliography. It was deliberately omitted because the authors felt it would serve no useful purpose and would be too extensive. The omission has been compensated for by a list of suggested additional reading from which the interested physician can make his selection.

Although the book does not bring anything new from a clinical viewpoint to the field of pulmonary physiology, the authors have given us a well written, concise work of value to all those interested in cardio-pulmonary disease. It is a useful addition to the reference shelf of books dealing with pulmonary disease and physiology.

ORLANDO M. ARMADA, M.D.

MECHANISMS OF DISEASE. An Introduction to Pathology by Ruy Perez-Tamayo, M.D. W. B. Saunders Co., Phil., 1961. $14.00

This book is an excellent English translation and adaptation of the author's *Principios de Patologia.* The book, published in easily readable double columns, succeeds in giving a dynamic physiochemical interpretation and explanation to those processes usually studied under General Pathology, such as: inflammation, degenerative and regressive disturbances, repair, regeneration, and neoplasia.

The introduction presents a short, interesting, historic résumé, illustrated by drawings and photographs of numerous outstanding pathologists and scientists of the recent and more remote past. The book is excellently illustrated by many photomicrographs and photographs of gross specimens. The reviewer takes exception to one very minor fault, namely, that numerous and sometimes rather ludicrous errors have been made in transcribing the titles of German articles in the bibliography, otherwise extensive and excellent.

In summation, this is a very comprehensive and scholarly work, worthwhile having on one's shelf as a reference work. It cannot replace, however, the more familiar and standard books on pathology.

L. W. FALKINBURG, M.D.

VIRUS MENINGO-ENCEPHALITIS. Ciba Foundation Study Group No. 7. In Honour of Prof. K. Todorovic. Editors: G. E. W. Wolstenholme and Margaret P. Cameron. Little, Brown & Co., Boston, 1961. $2.50

This is a concise elaboration on VIRUS MENINGO-ENCEPHALITIS encompassing a résumé on other viruses — Echo, Coxsackie, Polio, Tick-borne encephalitis, Arbo-virus, and Post-infectious virus encephalitis.

We all realize that virology is a new and rapidly expanding field. Each day new viruses are being discovered. Consequently, even this book which hasn't been out too long is slightly devoid of more recent information. For practical purposes, however, it does review the different groups in a clinical manner which is most informative. Since laboratory facilities aren't fully developed or practical at the present time for diagnosing each specific virus, we are only concerned with some clinical characteristics of each group. The treatment in general is supportive and nonspecific. The problem which has always confronted us in the practice of medicine is to distinguish between a bacterial and a viral infection. Perhaps in the future as the laboratory diagnosis becomes easier and laboratory facilities are more easily available for separating these various viruses, it will be peremptory to make a specific viral diagnosis in each case.

I would recommend reading this short résumé on VIRUS MENINGO-ENCEPHALITIS and viruses in general.

HENRY J. KRAWCZYK, M.D.

DID YOU KNOW?

- That there are 1,500,000 diabetics in the United States who have been diagnosed and are under medical care, but that there are some 1,250,000 persons walking around with diabetes who don't know it.
- That the most likely targets for diabetes are persons related to diabetics, because it is hereditary.
- That diabetes can't be cured, but it can be controlled by diet, exercise, and, when necessary, by insulin, so that victims can lead fairly normal lives.

Sesquicentennial Celebration Dates

SCIENTIFIC MEETING

May 8 and 9, 1962

Marvel Gymnasium, Brown University



"Notice any change, Mrs. T.?" *"Well, Doctor... When I realized that I looked forward to teaching... really enjoyed being with the children again... I knew things were better..."* "Ever feel light-headed?" *"No... not at all. I feel perfectly normal now..."*

this could be your "anxiety patient" on

TREPIDONE®

MEPHENOXALONE LEDERLE

In the treatment of mild to moderate tension and anxiety, the normalizing effect of TREPIDONE leaves the patient emotionally stable, mentally alert. Adult dose: One 400 mg. tablet, four times daily. Supplied: Half-scored tablets, 400 mg., bottle of 50.

Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle



"cramps" don't cramp her style...

when you prescribe

Trancoprin®

Aspirin.....(5 grains) 300 mg.
Trancopal® (brand of chlormezanone).....50 mg.

Trancoprin is more than a simple analgesic: It deals with cramping pains in three ways. Besides dimming pain perception, Trancoprin, through its tranquilizing action, reduces anxiety and raises the tolerance for discomfort. And, against the spasm caused by pain which, in turn, produces more pain, Trancoprin exerts its skeletal muscle relaxant action.

Trancoprin is exceptionally safe to use: Fewer than two and a half per cent of patients can be expected to have any side effects, and these are of a minor nature.

Available in bottles of 100 tablets. The usual dosage in dysmenorrhea is 2 tablets 3 or 4 times daily.

Winthrop LABORATORIES, New York 18, N.Y.

Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications. 1602M

The extra-firm mattress selected by over 9,000 doctors for their own use

Assures both preventive and corrective support—used in more American homes than any other special design

Sealy Posturepedic is the first mattress designed in cooperation with leading orthopedic surgeons to promote normal, healthful sleep among *all* persons.

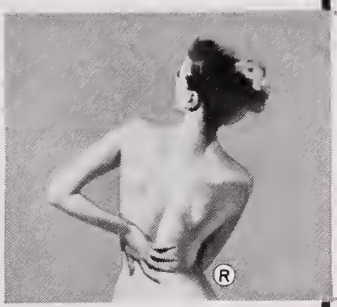
As a "corrective device" it serves those chronically afflicted with lower back syndromes. As a preventive measure Sealy Posturepedic brings deep spring buoyancy without bedboard hardness to everyone—plus the concomitant blessings of unexcelled comfort and extra-firm support.

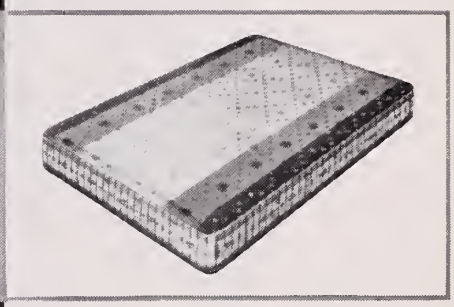
These are basic to good health. The therapeutic value of restful sleep is especially recognized during these tense and anxious days. Sealy Posturepedic eminently meets this need by supplying level spine support for proper relaxation of the limbs and human musculatory system.

Over 9,000 doctors of medicine have tried and bought the Sealy Posturepedic mattress and matching foundation for their own use. We believe your investigation will firmly convince you of its distinctive benefits, and, we would hope, merit your valued recommendation.

Sealy POSTUREPEDIC® BRAND

NO MORNING BACKACHE
from a too-soft mattress





PROFESSIONAL DISCOUNT OF $39.00

So that you may judge the quality of the Sealy Posturepedic for yourself, we offer a special Professional Discount on this mattress and foundation when purchased for your personal use. *Limit—one full or two twin size sets.*

SEALY MATTRESS COMPANY • Oakville, Conn.

Enclosed is my check and letterhead. Please ship the Sealy Posturepedic Set(s) indicated below:

1 Full Size ☐ **1 Twin Size** ☐ **2 Twin Size** ☐

	RETAIL		PROFESSIONAL
Posturepedic Mattress	each $79.50	(add state tax)	$60.00
Posturepedic Foundation	each $79.50	(add state tax)	$60.00

NAME_____

RESIDENCE_____

CITY_____ ZONE_____ STATE_____

(This is a saving of $39.00 per set over the regular $159.00 retail price for mattress and matching foundation)

©Sealy, Inc., 1958

LIFE INSURANCE or DEATH INSURANCE?

SOME Medical men need DEATH Insurance ONLY.

Others need accumulating, guaranteed dollar values to meet their LIVING needs in the future — DEPRESSION — EMERGENCY — RETIREMENT, etc.

In any event, our new "CHEAPER-THAN-TERM" DEATH INSURANCE is the first step in the right direction!

Don't make any important changes in your Life Insurance or Estate plans without investigating "CHEAPER-THAN-TERM"!

For further information about this sensational new development in DEATH INSURANCE, write or phone:

ROLAND A. DEROSIER
32 Custom House Street
Providence 3, Rhode Island
GA 1-1391



Fuller

Memorial Sanitarium

Located on Rt. 1

South Attleboro, Massachusetts

A modern non-profit hospital for the care and treatment of nervous and emotional disorders as well as long term geriatric problems.

Physical, neurological, psychiatric and psychological examinations.

Modern recognized psychiatric therapies.

A pleasant homelike atmosphere in a beautiful and conveniently located institution.

L. A. Senseman, M.D., F.A.P.A., Medical Director
Edwin Dunlop, M.D. Michael G. Touloumtzis, M.A.
Oliver S. Lindberg, M.D. William H. Dunn, M.S.W.
W. H. Lesovsky, M.D., Ph.D.

Referred patients are seen daily (except Saturdays) 9-12 A.M., and by appointment.
R. I. Blue Cross Benefits Tel. Southgate 1-8500

Special Rates for Long-Term Care



Wherever you go forget your telephone calls. We'll take them for you, day or night.

MEDICAL BUREAU

of the

Providence Medical Association

asthma attack averted
. . . in minutes



patient protected
. . . for hours



Nephenalin®
(the dual-action anti-asthmatic tablet)

. . . works with nebulizer speed—provides four-hour protection

One NEPHENALIN tablet provides: *air in a hurry*—through sublingual isoproterenol HCl, 10 mg. *air for hours*—through theophylline, 2 gr.; ephedrine, ⅜ gr.; phenobarbital, ⅛ gr.
Dosage: Hold one NEPHENALIN tablet under the tongue for five minutes to abort the asthmatic attack promptly. Then swallow the tablet core for four full hours' protection against further attack. Only one tablet should be taken every four hours. No more than five tablets in 24 hours.
Supplied: Bottles of 50 tablets. For children: NEPHENALIN Pediatric, bottles of 50 tablets.
Caution: Do not administer NEPHENALIN with epinephrine. The two medications may be alternated at 4-hour intervals. NEPHENALIN should be administered with caution to patients with hyperthyroidism, acute coronary disease, cardiac asthma, limited cardiac reserve, acute myocardial damage, and to those hypersensitive to sympathomimetic amines. Phenobarbital may be habit forming. THOS. LEEMING & CO., INC., New York 17, N.Y.



PRO-BANTHĪNE P.A.®

(BRAND OF PROPANTHELINE BROMIDE)

PROLONGED-ACTING TABLETS—30 mg.

Effective • Convenient • Sustained Action

PRO-BANTHĪNE®, the leading anticholinergic, is now available in a distinctive prolonged-acting dosage form.

The prolonged action of new PRO-BANTHĪNE P.A. is regulated by simple physical solubility. Each PRO-BANTHĪNE P.A. tablet releases about half of its 30 mg. promptly to establish the usual therapeutic dosage level. The remainder is released at a rate designed to compensate for the metabolic inactivation of earlier increments.

This regulated therapeutic continuity maintains the dependable anticholinergic activity of PRO-BANTHĪNE all day and all night with only two tablets daily in most patients.

New PRO-BANTHĪNE P.A. will be of particular benefit in controlling acid secretion, pain and discomfort both day and night in ulcer patients and in inhibiting excess acidity and motility in patients with peptic ulcer, gastritis, pylorospasm, biliary dyskinesia and functional gastrointestinal disorders.

Suggested Adult Dosage: One tablet at bedtime and one in the morning, supplemented, if necessary, by additional tablets of PRO-BANTHĪNE P.A. or standard PRO-BANTHĪNE to meet individual requirements.

G. D. SEARLE & CO.
CHICAGO 80, ILLINOIS
Research in the Service of Medicine

The RHODE ISLAND MEDICAL JOURNAL

VOL. XLV FEBRUARY, 1962 NO. 2

CLOSED CHEST CARDIAC MASSAGE*

ROBERT L. CURRAN, M.D.; JOSEPH R. GAETA, M.D.; FRANK MERLINO, M.D., AND LESTER L. VARGAS, M.D.

Authors. †*Robert L. Curran, M.D., Assistant Physician, Rhode Island Hospital, Providence, Rhode Island.*

†*Joseph R. Gaeta, M.D., Resident-in-Medicine, Veterans Administration Hospital, Boston, Massachusetts.*

Frank Merlino, M.D., Associate Cardiologist, Rhode Island Hospital, Providence, Rhode Island.

Lester L. Vargas, M.D., Surgeon-in-Chief and Director of Cardiovascular Research Laboratory, Rhode Island Hospital, Providence, Rhode Island.

CARDIAC ARREST, occurring either as ventricular standstill or fibrillation, results in a cessation of cardiac output. When this happens, circulation must be promptly restored; otherwise, anoxia produces irreversible damage. Until recently, thoracotomy with open-chest cardiac massage has been used in the management of this emergency. This procedure, although useful, has been a formidable undertaking, particularly when done away from the operating room.

Recently, several authors have described closed chest cardiac massage.[1-3] This article will review the technique and report four cases in which it was used.

Method

The technique is not difficult. The principle employed takes advantage of certain anatomic features of the thorax. The heart is limited anteriorly by the sternum and posteriorly by the vertebral bodies. Lateral movement is restricted by the pericardium. Therefore, pressure on the sternum compresses the heart and forces blood into the great vessels. The negative intrathoracic pressure which occurs on relaxation promotes right-heart filling.

When the diagnosis of cardiac arrest has been made, the patient must promptly be placed on a firm surface. Bed patients should be moved to the floor. The heel of one hand is applied to the lower sternum. The second hand is placed above. Rhythmic downward pressure is applied sixty to eighty times each minute. The sternum is forced four to five centimeters toward the vertebral column. Complete expansion of the chest must occur after each compression.

Ventilation must be provided simultaneously. If two or more persons are available, one may give mouth-to-mouth respiration. When only one person is present, an alternation of ventilation and cardiac massage — three or four ventilations followed by thirty seconds of massage — should be done. Insertion of an endotracheal tube should be performed as soon as possible to allow intermittent positive pressure breathing.

The effectiveness of cardiac massage and artificial respiration can be confirmed by certain observations:

1. The pupils will constrict or remain constricted.
2. Spontaneous respirations may occur.
3. Femoral and carotid pulses will be palpable, and a blood pressure may be measured.
4. Spontaneous cardiac activity may return.

The steps described above are emergency resuscitative measures. The actual nature of the cardiac disorder, ventricular standstill or fibrillation, determines subsequent therapy. If standstill is present, cardiac resuscitation may be restored by closed chest massage alone or may require, in addition, any one or all of the following measures: 1) external pacemaker, 2) intravenous isoproteranol, and 3) intravenous, or intracardiac epinephrine, or both. Intravenous calcium salts are of aid in increasing myocardial tone. If ventricular fibrillation is present, the heart must first be defibrillated. Several appliances, now commercially available, may be used for external countershock. Their effectiveness is virtually equal to that obtained with internal defibrillation.

At any time during the course of treatment, cardiac arrhythmias may occur. Appropriate drug therapy, e.g., digitalis, procaine amide, quinidine, norepinephrine, potassium salts, or sodium bicarbonate, will depend on the nature of the problem. It is to be emphasized that early and effective cardiac output combined with adequate ventilation are the goals of management.

continued on next page

*From the Departments of Cardiology and the Cardiovascular Research Laboratory of the Rhode Island Hospital, Providence, Rhode Island. Supported by a grant from the John A. Hartford Foundation, Inc.

†Fellows-in-Cardiology, Rhode Island Hospital, Providence, Rhode Island — 1960-1961.

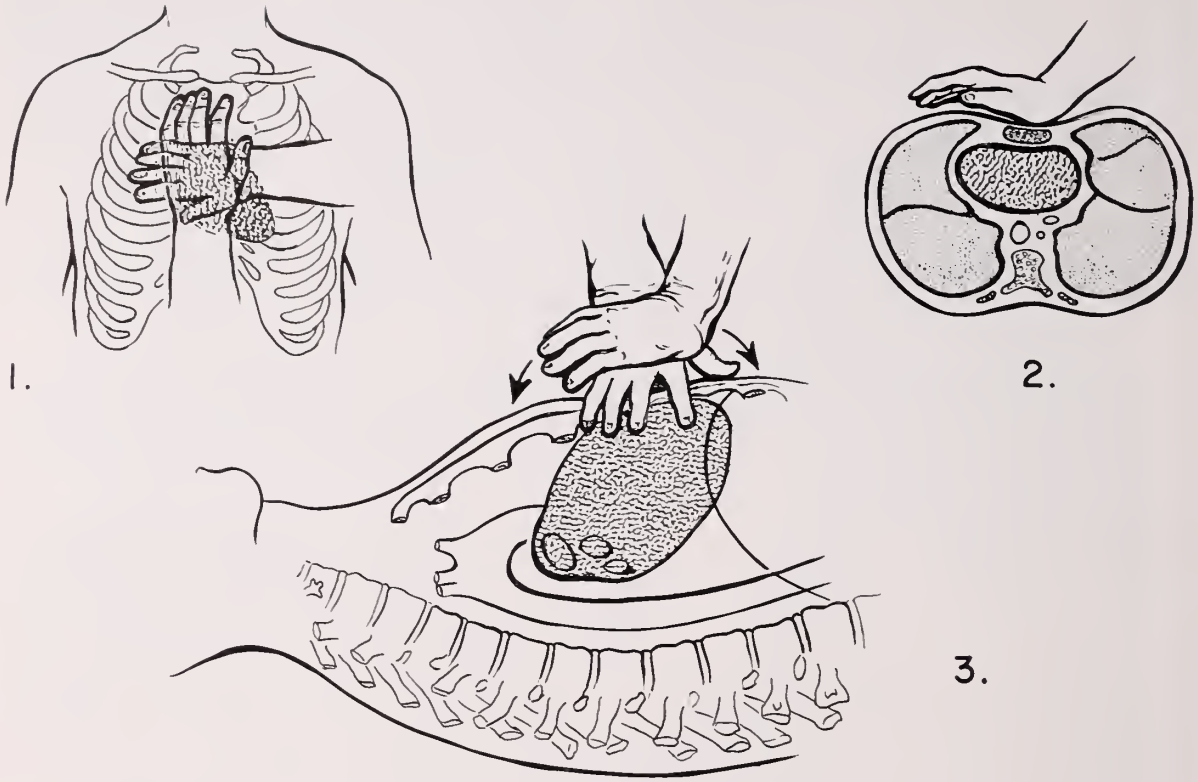


FIGURE I

Diagram illustrating technique of external cardiac massage in: 1) posterioanterior, 2) horizontal and 3) sagittal views.

Case Reports

Case I: A.B., a seventy-year-old male, who had been hospitalized in February, 1961, for a posterolateral myocardial infarction, was admitted to the Rhode Island Hospital Accident Room on April 25, 1961, without audible blood pressure or pulse. External cardiac massage was performed for over one hour. Since the external defibrillator was not available, thoracotomy and internal defibrillation were carried out. The rhythm changed to a ventricular tachycardia. Intravenous procaine amide restored a normal sinus rhythm. Blood pressure was maintained with intravenous norepinephrine. At the termination of the procedure, the patient regained consciousness and complained of pain. Serial electrocardiograms demonstrated re-infarction in the posterior myocardium. Treatment consisted of maintenance digitalis, procaine amide because of multiple ventricular extrasystoles, anticoagulation, and intramuscular penicillin. Vasopressors were necessary for three days and then were tapered gradually. The thoracotomy wound healed well. He was discharged on his thirty-seventh hospital day.

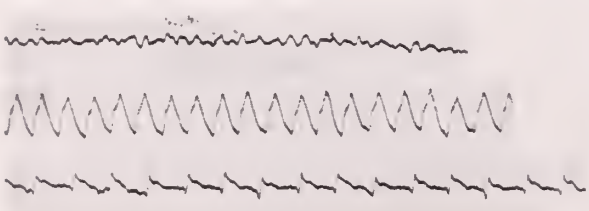


FIGURE II

Strips of serial electrocardiograms (Lead II) in Case I demonstrating ventricular fibrillation, ventricular tachycardia, normal sinus rhythm with evidence of posterior infarction.

Comment: This case illustrates successful resuscitation in an elderly patient with arteriosclerotic heart disease following a prolonged period of external cardiac massage.

Case II: E.M., a sixty-two-year-old hypertensive male, was admitted to the Rhode Island Hospital on May 24, 1961 with an open comminuted fracture of the left ulna and radius. Closed manipulation on May 24 was followed by open reduction on May 25. However, ischemic necrosis of the left arm necessitated mid-forearm amputation on July 3. Initial electrocardiograms demonstrated evidence of previous posterolateral infarction and ventricular irritability. On July 22 he suddenly became unresponsive. External cardiac massage and artificial respiration by an endotracheal tube were immediately instituted. The electrocardiogram

showed ventricular fibrillation. Successful external defibrillation resulted in a nodal bradycardia. Small doses of intravenous procaine amide controlled episodes of ventricular tachycardia. Blood pressure was maintained with intravenous vasopressors. Although serial serum glutamic oxaloacetic transaminase determinations were 114, 54, and 18, serial electrocardiograms did not demonstrate re-infarction conclusively. Initially, he responded to verbal commands. However, he gradually lapsed into a semi-comatose state, developed hypostatic pneumonia and died on July 30.

Comment: This case illustrates successful cardiac resuscitation but with ultimate death occurring secondary to cerebral hypoxia.

Case III: Immediately following completion of surgical repair of the mitral valve with the aid of cardiopulmonary bypass, G.P., a forty-year-old female with well-documented mitral stenosis and regurgitation, developed ventricular fibrillation. Direct arterial blood pressure and electrocardiogram were being monitored at the time and they provided objective evidence of the effectiveness of external cardiac massage and external defibrillation. Unfortunately, the physiological response was only transient. Death occurred five hours later.

Case IV: H.S., an eighty-one-year-old female, was admitted to the Rhode Island Hospital on April 19, 1961 with a one-day history of abdominal pain and evidence of peripheral vascular collapse. Examination revealed a right lower quadrant mass. At laparotomy, rupture of an aneurysm of the hypogastric artery with associated massive retroperitoneal hematoma was found. After proximal and

concluded on next page

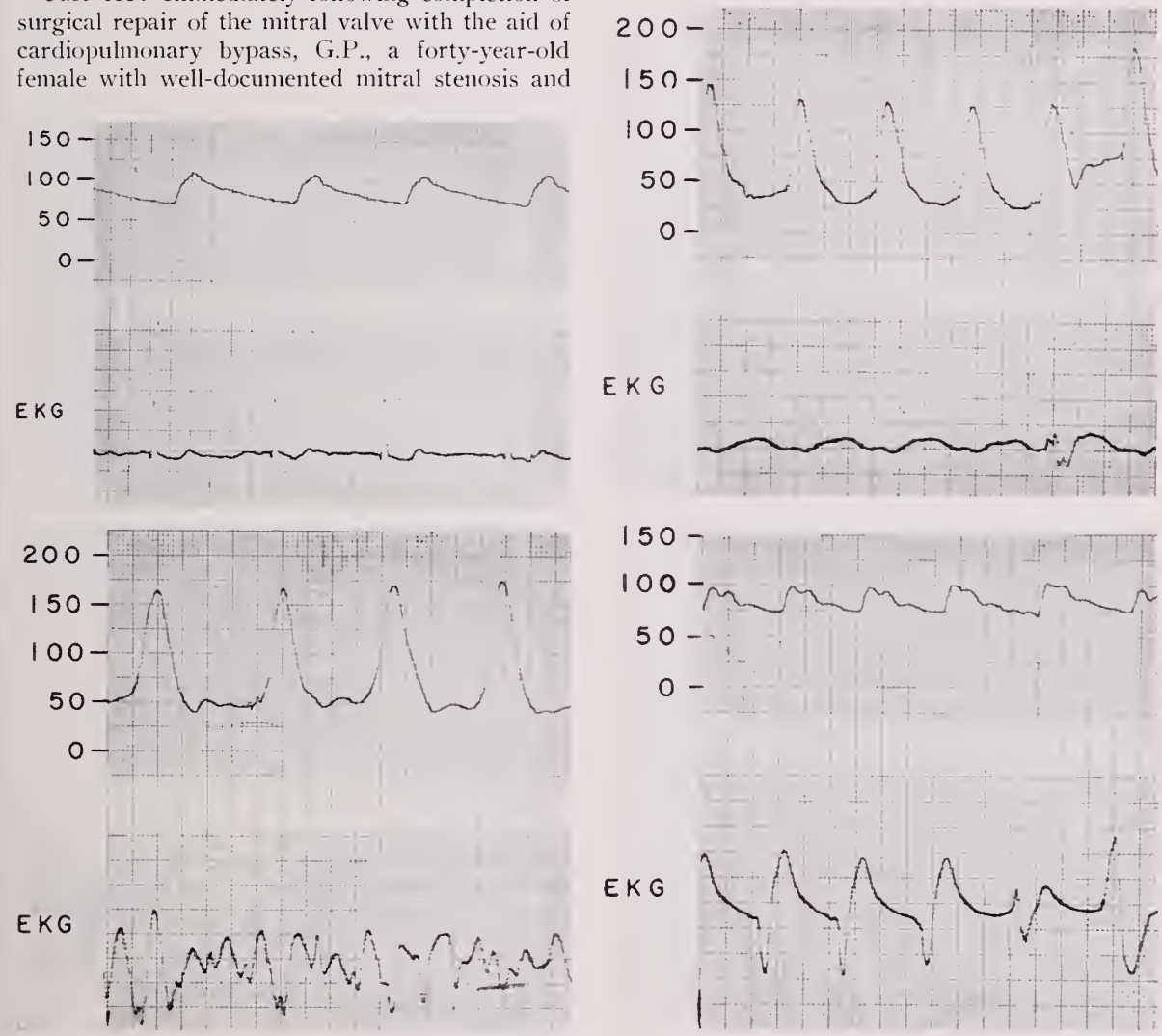


FIGURE III

Serial records of electrocardiogram and pulse pressure tracings in Case III:

a) Preoperative record demonstrates auricular fibrillation, blood pressure of 108/72.

b) Ventricular fibrillation with external cardiac massage — blood pressure 165/40.

c) Ventricular standstill with external cardiac massage — blood pressure 130/30.

d) Brief restoration of patient's intrinsic rhythm — idioventricular. Blood pressure 98/75.

distal control of the diseased vessel and during the vascular anatomosis, blood pressure, pulse, and aortic pulsations disappeared. Ninety seconds after external cardiac massage was begun, aortic pulsations returned. Replacement transfusion continued. Except for transient small bowel ileus, her postoperative course was uneventful, and she was discharged on her nineteenth postoperative day.

Comment: This case illustrates closed chest massage resulting in the restoration of normal cardiac rhythm and function during surgery.

Discussion

Kouwenhoven and his associates[1] have shown by experiments in dogs that an adequate cardiac output and systemic blood pressure could be maintained by external cardiac massage during induced ventricular fibrillation. They were able immediately to resuscitate 14 out of 20 patients who developed cardiac arrest. Ventricular fibrillation was present in three patients. The duration of massage ranged from seconds to more than sixty-five minutes. In a patient in whom ventricular fibrillation developed during the course of left heart catheterization by the retrograde aortic technique, Gurewich et al.[2] demonstrated, by direct arterial recordings, that an adequate blood pressure could be maintained by external massage. Barringer and his associates[3] reviewed eighty-four cases at the Massachusetts General Hospital. The series included all cases, irrespective of the nature and extent of the underlying disease or duration of massage. The over-all survival was small; only four patients were ultimately discharged from the hospital.

The cases reported above illustrate successful application of the technique of external cardiac massage. Two of the four, including one with ventricular fibrillation, survived and were discharged from the hospital. The data collected during efforts to resuscitate our third patient graphically demonstrate the value of the method.

Considering the nature of the underlying disease process, the over-all survival rate will be small. Indeed, this method should not be used in all cases. It is not indicated in terminal stages of illnesses which are irreversible by present knowledge, or where the duration of cerebral anoxia is greater than five minutes.

The method is best suited for cases of sudden unexpected deaths. These have resulted from myocardial infarctions, drug reactions, anesthesia accidents, and electrocutions, and have occurred during cardiac catheterizations.

Certain complications, e.g., fractured ribs, laceration of the abdominal viscera, hemothorax, hemopericardium, or both, and marrow emboli, have been reported.[1-4] The incidence of these complications should be reduced as experience with the use of the technique increases. The benefits of the procedure will outweigh the risk of complications when the diagnosis of circulatory arrest is established with a reasonable degree of certainty.

SUMMARY

Closed chest cardiac massage is a relatively simple, practical, and effective method of maintaining circulation when cardiac arrest occurs. The technique for carrying out the procedure has been described and the importance of maintaining adequate oxygenation has been emphasized. Four cases have been presented in which the method was used successfully in maintaining an adequate circulation. Two of these ultimately survived and were discharged from the hospital. The literature has been briefly reviewed.

References

[1]Kouwenhoven, W. B.; Jude, J. R., and Knickerbocker, G. G.: Closed Chest Cardiac Massage. J.A.M.A., 173: 1064-1067, 1960

[2]Gurewich, V.; Sasahara, A.; Quinn, J.; Peffer, C., and Littman, D.: Aortic Pressures During Closed Chest Cardiac Massage. Circulation, 23:593-596, 1961

[3]Barringer, J.; Salzman, E.; Jones, W., and Friedlich, A.: External Cardiac Massage, N. England J. Med., 265:62-65, 1961

[4]Morgan, R.: Laceration of the Liver from Closed Chest Cardiac Massage. N. England J. Med., 265:82-83, 1961

Medical Operation — An operation has lately been performed by Dr. Weeden, of Bristol, Rhode Island, for a harelip, in which the fissure was half an inch wide, and extended through the upper jaw and roof of the mouth. The child was eleven weeks old. Much difficulty was experienced from the cries and struggles of the child during the operation, but it was not followed by any alarming symptoms. Some of the most eminent surgeons formerly thought such an operation impractical. — Warren Star.

... Reprinted from *Providence Daily Journal*, August 1, 1833

HIKE PUBLIC HEALTH SPENDING

Federal, state and local governments now spend over $6 billion annually for health and medical programs, not counting the costs of medical-facilities construction.

In a review of health services provided or paid for by tax funds, the Social Security Administration reported such expenditures exceeded $6,228,400,000 in the fiscal year 1959-60. Ten years earlier, the tax outlay for health purposes was $3,322,500,000.

EXPOSITION OF HEALTH PROGRESS

April 6-16, 1962

Cranston Street Armory

INTERCOSTAL PHENOL NERVE BLOCK*

EDWARD DAMARJIAN, M.D.

The Author. *Edward Damarjian, M.D., Anesthesiologist, Department of Anesthesiology, the Memorial Hospital, Pawtucket, Rhode Island.*

IN THE PAST, the use of nerve blocks for the relief of pain of fractured ribs or intercostal neuralgia has been unsatisfactory. The return of pain following the short period of intercostal anesthesia has made this type of treatment unpopular. It has been rare for a single intercostal nerve block to give continued relief of pain in the presence of fractured ribs, thus requiring frequent doses of narcotics for several days. Daily intercostal blocks were not practical.

The ideal nerve blocking agent for continued relief of pain has yet to be found. The oily solutions of anesthetic drugs have been unsatisfactory. The effect of alcohol with its paresthesia and spreading tendency has been unreliable in my hands, except for such blocks as trigeminal and specific cervical nerves.[1] Paravertebral alcohol blocks have been discouraging because of their close proximity to the spinal cord.

Boiling water, as reported by Jaeger on the gasserion ganglion,[2] was tried on the mandibular and maxillary divisions of the trigeminal nerve and has been found to be not practical. Boiling water lasted only a few hours in the few cases in which I have used it on various somatic nerves, including the trigeminal branches, intercostal, and pudendal nerves. There are reports in the literature on the use of phenol (6 per cent) for nerve block. In these cases the phenol was used only on sympathetic nerves.

Phenol was originally used by Haxton[3] in 1949, and Mandl and Haxton[4] in 1950 as a substitute for alcohol in chemical sympathectomies. Doppler in 1926 experimented with various drugs such as acids, bases, alcohol, and ethers, and Bivet reported experiments which demonstrated that painting with 6 per cent phenol interrupts conductivity in the cervical sympathetics of rabbits. Binuet has often injected 50 ml. of phenol without untoward effects. Haxton reported two cases of sympathectomy done seven days after a phenol sympathetic block. In both patients there was edema of the surrounding tissues and some opacity of the sheath over the psoas muscle. The sympathetic chain appeared swollen, and its rami were easily broken. Histological examination revealed that the majority of the ganglion cells had lost their nuclei and were degenerating.

Swetlow suggested phenol as a substitute for alcohol in 1926, thus avoiding the irritating qualities of alcohol on the sympathetic nerves. Since that time phenol has been used by various individuals for chemical sympathectomy. Asher and Pearce used it on renal sympathetics. Haxton found that sympathetic blocks with phenol could last as long as two years, and that complications that occurred with alcohol did not occur with dilute phenol. Boyd, Ratcliff, Jepson, and James[5] have used 10 per cent aqueous phenol on sympathetic nerves in selected cases with good results. Bonica[6] reports good results following chemical sympathectomy with aqueous phenol lasting three to four weeks and in some cases as long as nine months. In blocking sympathetic nerves with alcohol, White[7] found unpleasant sensations and complications of intercostal neuralgia, followed by hyperesthesia of the chest wall which lasted for months. Mandl has shown that in cats 6 per cent phenol had a selective action on the sympathetic ganglia, causing complete destruction without damaging the spinal nerves. He obtained complete necrosis of the nerve elements following a stellate ganglion block. Only the connective tissues remained, and regeneration took place in 75 days. He also found that injection of 6 per cent phenol in skin, muscle, fascia, and pleura involved no danger of necrosis in these tissues. Ochsner in 1943 and DeTakats in 1946 abandoned the paravertebral injection of alcohol because of unpleasant complications. Iggo and Walsh[9] have used Myodil,® a phenol iodine which is opaque to X-ray, in intrathecal injections for the relief of chronic pain in cancer. Nathan and Sears[11] used dilute phenol on the spinal roots of cats. These, however, were the nearest approach to phenol injection in somatic nerves found in the literature. No reports could be found on the use of phenol on intercostal nerves in any reports pertaining to nerve block.

My results with 6 per cent aqueous phenol on the trigeminal branches, supracapular, and cervical nerves were not satisfactory. The anesthetic effect wore off quickly and in some instances was not

continued on next page

*From the Department of Anesthesiology, the Memorial Hospital, Pawtucket, Rhode Island. Presented at the Annual John F. Kenney Clinic at Memorial Hospital, October 25, 1961.

powerful enough to penetrate the nerve sheath. The small volume used made accurate blocking more difficult. However, I found that 6 per cent aqueous phenol could be used for intercostal neuralgia, especially for the relief of pain of fractured ribs. The anesthesia was not only adequate but lasted for several weeks. I began a series of intercostal phenol nerve blocks for other types of intercostal pain, such as neuralgia from malignancy, costo-chondral separation, and fractured ribs. The results were very gratifying. The intercostal anesthesia lasted for 6 to 8 weeks, thus making possible the omission of all medication for pain. Patients were allowed to sit in a chair or to become ambulatory, and the use of chest strapping was abandoned.

Technique

The solution of phenol is made by adding 30 drops of liquefied phenol (88 per cent) to each ounce (30 ml.) of water. A simple intercostal block of the ribs involved is first performed with 1 ml. of 2 per cent xylocaine.® This is immediately followed with the phenol intercostal block of the same ribs about 3 fingers' breath peripheral to the xylocaine® block, but still posterior to the site of fracture or injury (Figure 1). One ml. of phenol is used for each intercostal nerve. The anesthesia, resulting from the simple xylocaine,® blocks the pain that the subsequent phenol injection would ordinarily produce. It is important to inject posterior to the posterior axillary line to block the lateral cutaneous branch of the intercostal nerve. Blocking of ribs from T6 through T3 may be difficult. At times the vertebral border of the scapula can be pulled away from the midline of the spinal column by having the patient lie prone with the arm hanging off the side of the table. The block is done in routine fashion, injecting the lower border of each rib.

INTERCOSTAL PHENOL BLOCK

OF THE 8th RIB

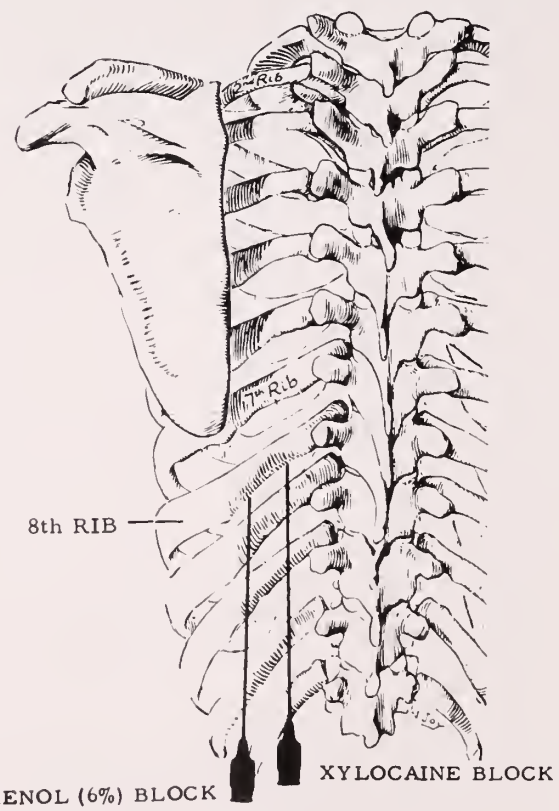


FIGURE I

Clinical Results

Forty-six patients were given intercostal blocks, of which 20 were for fractured ribs, 22 for intercostal neuralgia, and 4 for herpes zoster. The results in the fractured rib cases were, with one exception, all excellent. The exception was a Workmen's Compensation Act injury in a laborer with fracture of the seventh and eighth ribs on one side. In our enthusiastic attempt to send the patient back to work immediately after the block, the patient's family objected and insisted that the patient did not have complete relief of pain. The nonfracture cases varied from simple chest trauma to costo-chondral separation. All were relieved except one patient with post-operative neuralgia, who continued to complain of pain. It is important to note that patients with fractured ribs may also have costo-chondral separation of other ribs and that the phenol block may have to be repeated to include additional ribs. In the four cases of herpes zoster the results were fair. In one case a woman sustained fractures of the eighth, ninth, and tenth ribs on one side in a boating accident. Phenol block of the sixth through the eleventh ribs gave her complete relief of pain for 6 weeks, after which time the pain in the same area returned requiring a repetition of the block. Following the second block the pain did not return.

No complications have been encountered. To date, no neuralgia or post-injection neuropathy have occurred. I have not seen any neuralgic complications caused by the phenol injection entering the nerve cuff in the intervertebral area. The xylocaine® block placed more posterior than the phenol block may be a factor. If it is necessary to block all of the lower ribs, there may be a slight bulging in the flank region due to the relaxed musculature in that area. This will return to normal within two to six weeks. Repeat injections of phenol may be needed on subsequent visits either because of an error in technique or because of the development of new sensory pathways over other intercostal nerves. This is frequently seen in cases of herpes zoster. In the herpes zoster cases the patients admitted relief of the post-herpetic severe pain, but there was a residual soreness which was tolerable,

concluded on page 97

THE MILK-ALKALI SYNDROME

With Report of a Case

JOHANNES VIRKS, M.D., AND EZRA SHARP, M.D.

The Authors. *Johannes Virks, M.D., Assistant Physician, Department of Medicine, Miriam and Rhode Island hospitals; Clinical Director (Medical) State Hospital for Mental Diseases.*

Ezra Sharp, M.D., Chief, Department of Medicine, Miriam hospital; Associate Physician, Department of Medicine, Rhode Island hospital.

Definition and Incidence

THE MILK-ALKALI SYNDROME, a complication of peptic ulcer therapy, was clearly outlined in 1949 by Burnett and his co-workers.[1] However, alkalosis, azotemia, and elevated serum calcium as complications of the treatment of peptic ulcer with milk and alkali were described before Burnett (Grant 1922,[2] Hardt and Rivers 1923,[3] Cope 1936,[4] Kirsner and Palmer 1941, 1942[5, 6]).

The characteristic features of the Milk-Alkali Syndrome are a history of excessive and prolonged intake of milk and absorbable alkali, hypercalcemia without hypercalciuria, no hypophosphatemia, normal serum alkaline phosphatase, renal insufficiency with azotemia, mild alkalosis, and tissue calcinosis manifested especially by an ocular lesion resembling band keratitis.

The incidence of this type of chronic chemical disturbance, recognized during lifetime, is considered rather low. According to Wenger and his co-workers[7] it was observed in 35 patients out of 3,300 patients treated for peptic ulcer in the decade 1947-1956, an incidence of 1 per cent. On the other hand autopsy findings suggest a greater frequency. Becker and his associates[8] found calcification in the renal parenchyma in 36 per cent of 99 autopsied patients with chronic duodenal ulcer. They suggested that recurrent mild episodes of alkalosis, not recognized clinically, might be responsible.

Early recognition of alkalosis with hypercalcemia is important, as the prognosis is good after withdrawal of milk and absorbable alkali, while it is poor in cases of prolonged duration with tissue calcinosis and renal insufficiency. Burnett[1] reported four deaths in six patients.

Case Report

J. J. C., a fifty-one-year-old unemployed toolmaker, was admitted to the Miriam Hospital on August 26, 1958, complaining of epigastric pain, nausea, vomiting, and intermittent "black stools" of several weeks duration.

He had felt poorly since the spring of 1956, when he first noted epigastric pain. Later the epigastric pain was accompanied by nausea, vomiting, and "black stools." In July he was hospitalized in Hartford, Connecticut for one week. The patient stated that gastrointestinal X-ray studies were negative. However, on discharge from the hospital he was placed on an ulcer regimen of milk and cream, and several types of pills. While on this regimen the epigastric pain was relieved. In October of 1956 his previous symptoms recurred and in addition intense pubic and perineal pruritus. His eyes became watery and "pink." Whenever his ulcer symptoms recurred he returned to milk and cream and used Bisma-Rex,® a proprietary anti-acid and alkali. During the year prior to admission, he had been unable to work because of increasingly severe headaches, weakness, pruritus, "nervousness," intermittent epigastric pain, nausea, vomiting, constipation, and "black stools." His "nervousness" was consistent with an agitated depression. He consumed up to three quarts of milk daily and took Bisma-Rex® in increasing quantity and frequency. (Bisma-Rex® contains: Bismuth subcarbonate, aluminum hydroxide, magnesium trisilicate, sodium bicarbonate, calcium carbonate, magnesium carbonate, diastase, and oil of peppermint).

The past history was not remarkable. Prior to 1956 he had been hospitalized only once, in October 1952 at Pawtucket Memorial Hospital for repair of a right inguinal hernia, at which time all laboratory studies, including urinalysis and blood urea nitrogen, were within normal limits. He had consumed beer in moderate amounts up to one year ago, and had smoked one package of cigarettes (20) per day. Despite failing health, his body weight had been stable.

Physical examination revealed a well-developed, middle-aged man complaining of severe headaches and on the verge of crying. Weight 170 lbs.; blood pressure 125/80; pulse 82/min.; respiration 20/min.; temperature 98.8°F. by rectum. His upper

continued on next page

eyelids were slightly swollen. The bulbar conjunctiva of both eyes showed many dilated blood vessels. Adjacent to the limbus of the conjunctiva there was a deposition of white opaque material in the temporal and nasal conjunctiva of both eyes. The cornea of each eye showed a gray and hazy U-shaped zone, which extended from about the two o'clock position downward and around to the ten o'clock position. Slit-lamp examination showed, in addition to the U-shaped haziness, a thin gray band across the cornea, which in the right eye was continuous, in the left not yet a complete line. The gray areas in the cornea were composed of whitish-gray opaque material deposited just beneath the corneal epithelium. Within the U-shaped gray areas there were about five roughly circular areas just inside the limbus where the cornea remained clear. The lenses and vitreous bodies were clear. The eye-grounds were essentially normal. The lungs were resonant to percussion while on auscultation there were a few basal rales. The heart was not enlarged to percussion. Blood pressure 125/80. Rhythm regular, rate 82/min. A Grade II (I-VI) systolic murmur was heard at the lower left sternal border and over the apex. The liver edge was palpable 2-3 cm. below the right costal margin in the right mid-clavicular line. The spleen was not palpable. On deep palpation tenderness was elicited in the right mid-abdomen, below and separate from the edge of the liver. There was a herniorrhaphy scar in right inguinal area, and absence of the testicle in the right scrotal sac. Rectal examination was negative. The prostate was normal. The feces were dark brownish-green in color. The extremities showed no edema. The deep tendon reflexes were hyperactive and equal bilaterally. The femoral, popliteal, dorsalis pedis, and tibialis posterior pulsations were palpable and equal bilaterally.

Stools for occult blood were negative on repeated occasions. On 8/26/58 the hemoglobin was 10.7 gm. per 100 ml., hematocrit 31 per cent. The red blood cell count was 3.6 million; the white blood cell count was 12,400, with 75 per cent segmented neutrophils, 6 per cent band forms, and 19 per cent lymphocytes. Hemoglobin values on four occasions varied from 10.1 to 10.7 gm. per 100 ml., hematocrit was stable at 33 per cent. Thus no evidence of blood loss could be demonstrated. Urinalysis showed a fixed low specific gravity of 1.008-1.009, a trace of albumin, and a few white blood cells. Urine culture on 8/29/58 showed no growth. Fasting blood sugar 105 mg./100 ml. Serum cholesterol 272 and free cholesterol 161 mg. 100 ml. Serum acid phosphatase 1.6 Gutman units. Serum bilirubin, bromsulfalein excretion test, serum glutamic oxalacetic transaminase, cephalin flocculation, thymol turbidity, and prothrombin activity were within normal limits, as well as serum albumin and globulin on repeated determinations. In order to compute reliable serum calcium readings the serum proteins were determined simultaneously with the calcium and phosphorus.

The most significant laboratory findings were the elevated blood urea nitrogen and creatinine, elevated serum calcium, high normal CO_2 content, and increased blood pH (Table No. 1). The lowest serum Na value was 126 mEq./L. on 9/8/58. Yet the bladder urine contained a significant amount of sodium: 88 mEq. in 24-hour urine (Table No. 1). There was no restriction of sodium in the diet. The serum calcium was consistently elevated, showing the highest value of 13.3 mg./100 ml. on 9/13/58. The serum inorganic phosphorus at the same time was 4.6 mg./100 ml., i.e. high normal. Yet the urine calcium was low, only 16.7 mg. in 24-hour urine on 9/13/58. At this time the patient was on a low calcium diet, receiving 120 mg. of calcium in 24 hours. The kidney function was checked. Fishberg urine concentration test of 9/1/58 showed inability to concentrate urine above 1.009. Blood urea nitrogen and creatinine were persistently elevated (Table No. 1). Intravenous phenolsulfonphthalein test on 9/3/58 showed 2.5 per cent excretion of the dye in 15 minutes, 9 per cent in 30 minutes, 4 per cent in 60 minutes, giving a total of 15.5 per cent excretion in one hour. Standard urea clearance on 9/5/58 was only 6.1 per cent of normal.

X-ray examination of the chest on 8/28/58 showed no demonstrable pathology. X-ray studies of the upper gastrointestinal tract of 8/28/58 revealed a deformed duodenal bulb and a giant duodenal ulcer. On 9/5/58 X-ray examination of both shoulders revealed a significant calcific deposit in the region of the right subacromial bursa. X-rays of the hands showed an increased calcium content of the bony structures. Special X-ray studies of the eyes revealed a somewhat irregular circumferential deposit of calcium about the margin of the sclera on each side. Electrocardiogram on 9/4/58 was within normal limits.

On the basis of history, physical examination, and laboratory findings a diagnosis of Milk-Alkali Syndrome was made. The patient was placed on a low calcium diet (120 mg. per 24 hours). Fluid intake up to 3,000 ml. daily was encouraged. Donnatal® tablets were given for epigastric pain. Meprobamate was used for nervousness. On September 8, 1958, when the serum sodium was only 126 mEq./L., patient was placed on sodium chloride tablets by mouth, initially eight grams daily, thereafter four grams daily. While weakness and anorexia associated with low serum sodium subsided rapidly, no edema developed. His serum

sodium three days later was 137 mEq. L. (Table No. 1). His twenty-four-hour urinary output varied between 1,500-2,500 ml.; specific gravity remained low, below 1.010. His blood urea nitrogen and creatinine decreased to 66 and 4.8 mg./100 ml. respectively on 9/13/58 (Table No. 1). Despite the low calcium diet his serum calcium did not decrease. On the contrary, the serum calcium increased somewhat, reaching a value of 13.3 mg./100 ml. on September 13, 1958. The urinary excretion of calcium was low, reaching its lowest level of 16.7 mg. in twenty-four hours on September 13, 1958 (Table No. 1). Parallel to the decrease in blood urea nitrogen patient's general condition improved: his headaches and pruritus were less intense, the epigastric pain less frequent. He continued to complain of photophobia and irritation of the eyes.

On September 17, 1958 the patient was transferred to Massachusetts Memorial Hospital for more elaborate studies of calcium and sodium balance and kidney function. The results were comparable to those at the Miriam Hospital. However, the CO_2 content of the serum was considerably higher: 37.3 mEq./L. on 9/18/58 (Table No. 1). The high serum CO_2 content and elevated blood pH of 7.47 left no doubt that the patient was suffering from metabolic alkalosis in addition to hypercalcemia. An additional X-ray finding was a suggestion of early diffuse medullary calcification in the kidneys.

At the Massachusetts Memorial Hospital sodium chloride administration was omitted initially. Within 4 to 5 days patient developed postural hypotension, weakness, and anorexia. Serum sodium dropped to 122 mEq./L. on 9/23/58. This apparently was due to renal salt-wasting, because his twenty-four-hour urine, collected on the day that his serum sodium dropped, contained a total of 80 mEq. of sodium. Concomitantly with the fall in serum sodium, his blood urea nitrogen and creatinine began to rise, reaching a level of 66 and 5.8 mg./100 ml. respectively on 9/23/58 (Table No. 1). The administration of four grams of sodium chloride was resumed. The patient's condition improved. Unfortunately he would not stay long enough to permit the necessary sodium balance studies as related to intake and to the adrenal secretion of salt-retaining hormones. Patient was discharged from that hospital on 9/27/58. Discharge diagnosis: Milk-Alkali Syndrome. Recommendations: 1) Bland diet with frequent feedings and salt ad lib.; 2) No milk, cream, or absorbable alkali; 3) Amphogel® 30 cc. three times daily between meals; 4) tincture of belladonna 15 drops three times daily; 5) high fluid intake; 6) four grams of sodium chloride (oral tablets) daily; 7) surgical treatment of the duodenal ulcer as soon as patient's condition allowed.

Follow-up examination on 11/19/58 and 3/9/59 showed no essential change in the patient's condition or laboratory findings (Table No. 1). Hypercalcemia without hypophosphatemia persisted. Blood urea nitrogen and creatinine continued elevated.

On May 8, 1959 the patient was readmitted to the Miriam Hospital because of reactivation of his duodenal ulcer. Physical and laboratory findings were similar to those of the previous admission in August and September 1958. Surgical treatment for his duodenal ulcer was suggested. Patient refused surgery and was discharged on 5/12/59 on the same medical regimen. On 2/3/60 he was readmitted to the Miriam Hospital because of bleeding duodenal ulcer. His hemoglobin on admission was 4.3 gm./100 ml., hematocrit 15 per cent. He received whole blood transfusions. His bleeding stopped and he was discharged on 2/9/60. Because of the bleeding and the transfusions of whole blood, his blood chemistries of 2/8/60 (Table No. 1) could not be used for comparison with the previous studies. However, the normal serum calcium of 9.4 mg./100 ml. in the presence of elevated inorganic phosphorus and markedly elevated blood urea nitrogen and creatinine is noteworthy. Usually in patients with this degree of uremia, the serum calcium and CO_2 content are lowered. The normal serum calcium and CO_2 content of 2/8/60 in this patient was most likely due to pre-existent hypercalcemia and metabolic alkalosis.

At the time of writing (September, 1961) the patient is still alive, with intermittent ulcer symptoms of epigastric pain and vomiting. There are no changes in his physical findings. Unfortunately he has refused follow-up laboratory studies and surgery. However, he has abstained from milk and cream and absorbable alkali.

Pathogenesis

The important etiologic factors in Milk-Alkali Syndrome are excessive and prolonged intake of milk and absorbable alkali, such as sodium bicarbonate. Our patient had been suffering from ulcer symptoms for about two years prior to admission to the Miriam Hospital in August 1958. He had consumed up to three quarts of milk daily and had taken Bisma-Rex.®

The mechanism of the pathogenesis of this syndrome is not understood completely. The crucial biochemical disturbances observed are metabolic alkalosis, hypercalcemia, and azotemia. Since the kidneys are important in regulation of the internal environment and maintenance of the biochemical homeostasis, the pre-existing kidney disease has been considered to be an important factor in

continued on next page

the development of this syndrome.[7] In our case the history revealed no clinical symptoms suggestive of pre-existing kidney disease. Limited laboratory studies, including urinalysis and blood urea nitrogen six years prior to his present admission, were within normal limits. Burnett[1] and Randall[9] have shown convincingly that pre-existing renal damage is not a prerequisite for the development of this syndrome; yet renal insufficiency is an important concomitant. Is renal insufficiency secondary to alkalosis, to hypercalcemia, or to both?

Alkalosis and Potassium Depletion. The metabolic alkalosis which is an integral part of the syndrome is caused by the intake of absorbable alkali and the loss of chloride, hydrogen ions, and potassium in the gastric secretions through vomiting or gastric suction. If this loss of electrolytes is excessive the metabolic alkalosis may develop without the intake of absorbable alkali. This explains the development of metabolic alkalosis in Milk-Alkali Syndrome patients, who had used only non-absorbable alkali. Bland[10] stresses the importance of potassium deficiency in the development of metabolic alkalosis, caused by loss of potassium by vomiting and poor intake. The depletion of potassium causes some of the intracellular potassium ions to move out of cells with replacement by hydrogen and sodium ions. This is followed by a rise of bicarbonate ion concentration in the extracellular space, with resulting metabolic alkalosis. These changes affect the renal tubular mechanism. Normally, in reabsorption of sodium from tubular urine a competition exists between the secretion of hydrogen and potassium ions for exchange of sodium. In metabolic alkalosis the decreased availability of hydrogen ions favors additional losses of potassium in exchange for sodium. During severe potassium depletion hydrogen ion loss would be favored. Thus metabolic alkalosis and potassium loss are closely related and perpetuate one another. Metabolic alkalosis from any cause results in potassium depletion, while conversely potassium depletion ultimately results in metabolic alkalosis.

Claims that sustained metabolic alkalosis *per se* causes a decline in glomerular filtration and renal blood flow[7, 10] are not uniformly accepted.[11] However, potassium depletion does produce renal tubular lesions and impaired renal function.[12, 13] It appears likely, therefore, that the renal damage of Milk-Alkali Syndrome is initiated by the potassium depletion.

In our patient vomiting was frequent, with probable loss of potassium, chloride, and hydrogen ions; and in addition he consumed large amounts of Bisma-Rex,® which contains sodium bicarbonate. Metabolic alkalosis was evidenced by elevated blood pH and CO_2 content. Initially his serum potassium was rather low, but most subsequent determinations were normal. The electrocardiogram showed no evidence of hypopotassemia. Yet the possibility remains that the kidney impairment was initiated by hypopotassemia.

Hypercalcemia. As already stated potassium depletion is capable of producing renal impairment. However, Relman and Schwartz[12, 13] feel that the potassium depletion is not likely to produce overt uremia without other contributing factors.

In patients who develop the Milk-Alkali Syndrome the calcium intake has been excessive through consumption of excessive amounts of milk and antacids. In patients who consume up to three quarts of milk daily, the intake of calcium may be six or more times normal requirements, with concomitant increased absorption. Ordinarily with normally functioning kidneys the plasma level of calcium is not affected to any significant degree. With impaired renal function hypercalcemia without hypercalciuria, as in our case, may occur (See Table No. 1). Although potassium depletion and metabolic alkalosis may be major initial factors, the hypercalcemia *per se* may contribute to and aggravate the impairment of kidney function. Hypercalcemia is associated with polyuria,[14, 15] with resulting dehydration and impaired glomerular filtration. With the increased alkalinity of the tubular and peritubular fluids the excess calcium is deposited in the form of calcium salts in the tubular cells and interstitium and in other soft tissues. The pathogenesis of hypercalcemia and impairment of renal function associated with increased calcium intake without pre-existing or co-existing metabolic alkalosis and potassium depletion and without pre-existing kidney disease is not clear. Randall, et al.[9] have described such a syndrome in a patient with duodenal ulcer. Abnormalities in magnesium metabolism may play a part in the pathogenesis of Milk-Alkali Syndrome.[16] Rats fed a low magnesium diet developed calcium casts in the convoluted and collecting tubules of the kidneys, and necrotic lesions in both the glomeruli and tubules. A high calcium and normal magnesium intake in rats was accompanied by an alkaline urine, calciuria, and renal calculi, with a low serum magnesium and increased calcium. If the same interrelationship exists in man between the calcium and magnesium intake, then the magnesium deficiency, precipitated by high calcium intake, could be the major factor in the pathogenesis of Milk-Alkali Syndrome. In our case neither the serum magnesium level nor urinary excretion of magnesium was determined.

Sodium Depletion. Sodium depletion is not a characteristic of Milk-Alkali Syndrome. However, during two consecutive hospitalizations in different hospitals our patient developed clinical and laboratory evidence of a low sodium syndrome with

increasing weakness and drop in blood pressure. It should be mentioned that his sodium intake was not restricted. His serum sodium during the first episode of low sodium syndrome was 126 mEq./L. and during the second 122 mEq./L. Yet his twenty-four-hour urine contained a total of 88 mEq. of sodium during the first, and 80 mEq. of sodium during the second episode (See Table 1.). The low sodium syndrome was corrected within a few days by the administration of sodium chloride by mouth, 4-8 grams daily. These data suggest renal salt wasting. Only one fully studied case of Milk-Alkali Syndrome complicated by salt-losing nephritis could be found in the literature.[18] Frank[18] made reference to two additional incompletely studied cases. The impaired ability of the kidneys to conserve sodium in chronic renal disease has long been recognized. In long standing Milk-Alkali Syndrome with renal impairment the presence of renal salt-wasting is not surprising. On the other hand hyponatremia in early and mild cases could be caused by increased diuresis usually associated with hypercalcemia, without any demonstrable renal tubular damage. In either case it is important to recognize and correct the excessive loss of sodium, since sodium loss itself may cause deterioration of renal function.

It is recommended by Thorn et al.[19] that in cases of salt-losing nephritis the adrenal function should be measured in order to exclude Addison's disease as a cause. In our case unfortunately all planned studies could not be carried out. However, the patient showed no clinical evidence of Addison's disease.

Pathology

Whatever the sequence of biochemical disturbances in this syndrome may be, the kidney is the most important site of pathology. Calcium is deposited in the interstitium of the kidneys, in the tubular cells, and in the lumen of the tubules. In addition to tubular atrophy the glomeruli show either partial or complete hyalinization.[17] Calcium is also deposited in other soft tissues; and occasionally the bones show increased calcium content. In our case the calcium was deposited in kidney parenchyma, cornea, and in the right subacromial bursa. The bony structures of the hands showed increased calcium content.

Differential Diagnosis

The characteristic features of the Milk-Alkali Syndrome were clearly outlined by Burnett.[1] Several subsequent case reports and discussions have been published. There are some features which have not been stressed enough in the past. The loss of electrolytes in gastric content either by frequent vomiting or by gastric suction appears to be as important as the prolonged intake of milk and alkali. Vomiting and nausea over a prolonged period in intractable peptic ulcer patients who consume relatively large quantities of milk and alkali should suggest the possibility of this syndrome. Other suggestive clinical features are headaches, pruritus, irritability, depression, and constipation. The latter are manifestations of azotemia, of hypercalcemia, or of both. All of these were present in our case.

The most difficult problem is differentiation between primary hyperparathyroidism and Milk-Alkali Syndrome.[20, 21, 22] A high prevalence of peptic ulcer in patients with primary hyperparathyroidism adds to the difficulties. Laboratory studies are of great help. In hyperparathyroidism the hypercalcemia is usually accompanied by hypercalciuria, while the serum inorganic phosphorus is usually low. Hyperparathyroidism with impairment of renal function may produce a normal or elevated serum phosphorus without hypercalciuria. In this case the determination of the serum CO_2 combining power is of great help. In primary hyperparathyroidism the CO_2 combining power is either normal or low; in Milk-Alkali Syndrome it is elevated. In advanced primary hyperparathyroidism the bones show demineralization, and the serum alkaline phosphatase is elevated. In Milk-Alkali Syndrome no demineralization of bones is demonstrated, and the serum alkaline phosphatase is not elevated. The X-ray evidence of increased calcium content or osteosclerosis of the bones as demonstrated in our case speaks very strongly in favor of Milk-Alkali Syndrome. The incidence and frequency of osteosclerosis in Milk-Alkali Syndrome is not known. Review of the literature revealed only one reported case of generalized osteosclerosis in association with the Milk-Alkali Syndrome.[23] The low incidence of this finding may be due to the fact that not enough attention has been paid to it. Several other causes of hypercalcemia have to be considered, such as vitamin D intoxication, sarcoidosis, hyperthyroidism, neoplasm with and without skeletal lesions, Paget's disease, osteoporosis, multiple myeloma, and laboratory error.[22, 24] A proper history, and the physical and laboratory findings usually indicate the diagnosis without great difficulty. The diagnosis becomes increasingly complex if multiple causes are encountered, as for example hyperparathyroidism with Paget's disease,[25] and hyperparathyroidism with hyperthyroidism.[26]

Course, Treatment, and Prognosis

The course and prognosis of Milk-Alkali Syndrome depends upon the duration of the biochemical disturbance. The transient form of metabolic alkalosis with hypercalcemia, recognized early, has a good prognosis after withdrawal of excessive

continued on next page

milk and absorbable alkali, and after correction of electrolyte imbalances. The biochemical disturbance of long duration with tissue calcinosis and renal insufficiency has a poor prognosis, with treatment directed mainly to the kidney failure after eliminating the milk and absorbable alkali. In order to prevent further vomiting, surgical treatment for the peptic ulcer should be recommended whenever feasible. The ultimate prognosis of surgically treated cases of peptic ulcer with Milk-Alkali Syndrome depends upon the degree and reversibility of the kidney damage. Prevention of this eventually fatal complication of the treatment of peptic ulcer requires awareness of its symptoms and signs, such as frequent nausea and vomiting, constipation, pruritus, and irritability occurring in peptic ulcer patients on excessive and prolonged milk and alkali intake.

The best treatment is prevention. The exclusive milk and cream diet with alkali should be ordered only for short periods of time while the patients are under close observation. Particular caution should be exercised in patients with known pre-existing kidney disease. Timely surgery in patients with intractable peptic ulcer would certainly lessen the incidence of this complication.

In our case the intractable symptoms of the peptic ulcer in the form of frequent epigastric pain and vomiting had been present for about two years. The end-result of the two years of self-treatment was advanced kidney failure. Temporary biochemical improvement was obtained by the elimination of milk and cream and absorbable alkali from his regimen and attempted correction of the existing electrolyte imbalances. Surgery was refused. Despite the use of a more physiological conservative ulcer regimen, without milk and cream and absorbable alkali, he continued to have episodes of vomiting and also of bleeding. The episodes of vomiting have continued to aggravate the already existing biochemical imbalances. The five-year clinical course has been progressively down hill, and his further life-expectancy is determined by the residual kidney function.

Summary and Conclusions

A case of Milk-Alkali Syndrome, demonstrating the characteristic features of this condition, is presented. This patient, in addition, had a salt-losing nephritis, an infrequently observed complication of Milk-Alkali Syndrome, and also osteosclerosis, described in the literature in only one previously reported case.

The significance of metabolic alkalosis with potassium depletion and hypercalcemia, and the possible significance of magnesium deficiency, secondary to hypercalcemia, in the pathogenesis of renal insufficiency have been discussed. Pre-existing kidney disease does not appear to be a prerequisite for the development of this syndrome. However, when present, it is an aggravating and accelerating factor.

The Milk-Alkali Syndrome is a complex biochemical disorder, initiated by episodes of vomiting, and by excessive and prolonged intake of milk and absorbable alkali. When unrecognized and untreated, the end-result is renal failure. Only awareness and early recognition of its clinical and laboratory features will prevent fatalities. Close observation of patients with peptic ulcer treated exclusively with milk and alkali is recommended in order to prevent even transitory episodes of metabolic alkalosis and hypercalcemia.

References

[1]Burnett, C. H.; Commons, R. R.; Albright, F., and Howard, J. E.: Hypercalcemia Without Hypercalcuria or Hypophosphatemia, Calcinosis and Renal Insufficiency. New Engl. J. Med. 240:787; 1949

[2]Grant, S. B.: Tetany: A Report of Cases with Acid-Base Disturbance. Arch. Int. Med. 30:355; 1922

[3]Hardt, L. L., and Rivers, A. B.: Toxic Manifestations Following the Alkaline Treatment of Peptic Ulcer. Arch. Int. Med. 31:171; 1923

[4]Cope, C. L.: Base Changes in the Alkalosis Produced by the Treatment of Gastric Ulcers with Alkalies. Cl. Sc. 2:287; 1936

[5]Kirsner, J. B., and Palmer, W. L.: The Role of Chlorides in Alkalosis: Following the Administration of Calcium Carbonate. J.A.M.A. 116:384; 1941

[6]Kirsner, J. B., and Palmer, W. L.: Alkalosis Complicating the Sippy Treatment of Peptic Ulcer: An Analysis of 135 Episodes. Arch. Int. Med. 69:789; 1942

[7]Wenger, J.; Kirsner, J. B., and Palmer, W. L.: The Milk-Alkali Syndrome: Hypercalcemia, Alkalosis and Azotemia Following Calcium Carbonate and Milk Therapy of Peptic Ulcer. Gastroenterology 33:745; 1957

[8]Becker, D. L.; Baggenstoss, A. H., and Weir, J. F.: Parenchymal Calcification of the Kidneys in Patients with Duodenal Ulcer. Am. J. Clin. Path. 22:843; 1952

[9]Randall, Jr., R. E.; Strauss, M. B., and McNeely, W. F.: The Milk-Alkali Syndrome. A.M.A. Arch. Int. Med. 107:163; 1961

[10]Bland, J. H.: Clinical Recognition and Management of Disturbances of Body Fluids. W. B. Saunders Company, 1956; pp. 26; 356; 489; 344.

[11]Sanderson, P. H.: Renal Response to Massive Alkali Loading in the Human Subject. The Kidney, Ciba Foundation Symposium, edited by A. A. G. Lewis and G. E. W. Wolstenholme, Boston, Little, Brown and Company, 1954, pp. 165-176

[12]Relman, A. S., and Schwartz, W. B.: Nephropathy of Potassium Depletion: Clinical and Pathological Entity. New Engl. J. Med. 255:195; 1956

[13]Relman, A. S., and Schwartz, W. B.: The Kidney in Potassium Depletion. Am. J. Med. 24:764; 1958

[14]Dorhout Mees, E. J.: Disturbed Water Reabsorption by Renal Tubules in Two Patients with Hypercalcemia. Acta med. Scandinav. 157:199; 1957

[15]Epstein, F. H.; Rivera, M. J., and Carone, F. A.: The Effect of Hypercalcemia Induced by Calciferol upon Renal Concentrating Ability. J. Clin. Invest. 37:1702; 1958

[16]Wacker, W. E. C., and Vallee, B. L.: Magnesium Metabolism. New Engl. J. Med. 259:431; 1958

[17]Kessler, E.: Hypercalcemia and Renal Insufficiency Secondary to Excessive Milk and Alkali Intake. Ann. Int. Med. 42:324; 1955

[18]Frank, A., and Greenspan, G.: Milk-Alkali Syndrome Complicated by Salt-Losing Nephritis. New Engl. J. Med. 260:210; 1959

[19]Thorn, G. W.; Goldfien, A.; Suiter, Jr., T. B., and Dammin, G.: Hormonal Studies in Salt-Losing Nephritis. Med. Cl. N. Am. 44:1139; 1960

[20]Carpenter, H. M., and Pautler, E. E.: Hyperparathyroidism with Renal Insufficiency: Report of a Case Confused with the "Burnett Syndrome." New Engl. J. Med. 250: 453; 1954

[21]Kyle, L. H.: Differentiation of Hyperparathyroidism and the Milk-Alkali (Burnett) Syndrome. New Engl. J. Med. 251:1035; 1954

[22]Thomas, Jr., W. C.; Connor, T. B., and Morgan, H. G.: Diagnostic Consideration in Hypercalcemia with a Discussion of the Various Means by which such a State may Develop. New Engl. J. Med. 260:591; 1959

[23]Rifkind, B. M.; Chazan, B. I., and Aitchison, J. D.: Chronic Milk-Alkali Syndrome with Generalized Osteosclerosis after Prolonged Excessive Intake of "RENNIE'S" tablets. Brit. M. J. 1:317; 1960

[24]Editorial: Hypercalcemia-Doubled Causes and a Dilemma. Ann. Int. Med. 54:1026; 1961

[25]Kohn, N. N., and Myerson, R. M.: Hyperparathyroidism Associated with Paget's Disease. Ann. Int. Med. 54:985; 1961

[26]Jackson, C. E.; Webster, J. S.; Talbert, P. C., and Caylor, H. D.: Concomitant Hyperparathyroidism as a Cause of the Hypercalcemia Associated with Hyperthyroidism. Ann. Int. Med. 54:992; 1961

INTERCOSTAL PHENOL NERVE BLOCK

concluded from page 90

permitting patients to resume their occupation. There was no evidence of pleural irritation or pain as a result of the phenol injection.

SUMMARY

We have reported a new application of phenol as a nerve blocking agent. In the past it had been used mainly on sympathetic nerves. Forty-six cases of intercostal nerve block with 6 per cent aqueous phenol were performed in 20 cases of fractured ribs, 22 cases of intercostal neuralgia, and 4 cases of herpes zoster. The fractured rib cases became ambulatory immediately or at least were sitting up in a chair, and opiates and chest strapping were discontinued. Nearly all of the cases of intercostal neuralgia, mostly involving costo-chondral separation or trauma, were relieved of their pain long enough for the condition to heal. The four cases of herpes zoster had fair results.

References

[1]Damarjian, E.: Nerve Block — Diagnostic and Therapeutic. Rhode Island M. J., 34:202, 1951

[2]Jaeger, R.: Tic Douloureux: Permanent Cure by Injection of Hot Water into Gasserian Ganglion. J. Oral Surg., 16:395, 1958

[3]Haxton, H. A.: Chemical Sympathectomy. Brit. M. J., 1:1026, June 11, 1949

[4]Mandl, F.: Aqueous Solution of Phenol as Substitute for Alcohol in Sympathetic Block. J. Internat. Coll. Surgeons, 13:566, 1950

[5]Boyd, A. M.; Ratcliff, A. H.; Jepson, R. P., and James, G. W. H.: Intermittent Claudication. A Clinical Study. J. Bone & Joint Surg., 31B:325, 1949

[6]Bonica, J. J.: The Management of Pain. Lea & Febiger, Phil., 1953

[7]White, J. C., and Sweet, W. H.: Pain. Its Mechanisms and Neurosurgical Control. Charles Thomas, Springfield, Ill., 1955

[8]Damarjian, E.: Sympathetic Nerve Block. Rhode Island M. J., 33:466, 1950

[9]Iggo, A., and Walsh, E. G.: Selective Block of Small Fibres in the Spinal Roots by Phenol. Brain, 83:701, 1960

[10]Parmley, J., and Adriani, J.: Therapeutic Nerve Blocking. South M. J., 49:1110, 1956

[11]Nathan, P. W., and Sears, T. A.: Effects of Phenol on Nervous Conduction. J. Physiol., 150:565, 1960

TABLE NO. 1 (THE MILK-ALKALI SYNDROME)

Laboratory Data

Date	Serum										Urine	
	pH (Venous blood)	BUN mg/100 ml.	Creatinine mg/100 ml.	Ca mg/100 ml.	P mg/100 ml.	Alkaline Phosphatase Bodansky Units	Na mEq./L.	K. mEq./L.	C mEq./L.	CO_2 mEq./L.	Ca mg/24 hrs.	Na mEq./24 hrs.
10/3/52		16.0	1									
8/28/58		101.0	6.8	10.5	7.7	5	130	3.6	100	28		
9/2/58		114.9	7.4	11.0	6.4	4.4	138	4.0	100	26		
9/8/58		110.0	7.1	12.4	6.3	3.5	126	4.0	100	24	22.4	88
9/11/58	7.5	86.5	5.7	11.7	4.9		137	4.6	110	27	16.8	
9/13/58		66.0	4.8	13.3	4.6		136	4.4	110	27	16.7	
9/18/58	7.47	49.0	2.0	11.8	3.8	3.3	139	4.3		37.3	50	
9/23/58		66.0	5.8				122					80
9/26/58				11.4						31		
11/19/58		46.0	2.8	11.8	4.3	3.3	130	3.8	105	27		
3/9/59		56.2	4.8	13.1	2.9	4.4	135	3.1	100	25		
5/11/59		57.0	5.0	13.1	2.9	3.9	133	4.4	100	28	17.7	14
2/7/60		117.5	5.5	9.4	8.8	5.0	134	4.4	100	25		

REFLECTIONS ON THE KING-ANDERSON BILL (H.R. 4222)*

Part II, H.R. 4222, As an Insurance Plan

Reverend Stanley Parry, C.S.C., Ph.D.

The Author, *Reverend Stanley Parry, C.S.C., Ph.D., of South Bend, Indiana, Chairman, Department of Political Science, University of Notre Dame, South Bend, Indiana.*

THE BILL is not too clear about precisely what condition it intends to relieve through the principle of preventive intervention. It would seem that it intends to relieve medical indigence. But equally prominent in the intention is the idea that it will relieve 1) the burden of medical welfare from the general revenues, 2) the facilities of hospitals and private agencies. The basic plan, however, is clear enough. The causative condition from which the evils to be remedied flow is identified as the inability of "most" aged to "qualify for and to afford" voluntary health insurance. This, consequently, forces "many" to apply for private or public aid. The bill, therefore, bases its remedy in a system of what it calls "social insurance," the modifier "social" importing in this context that society is to be protected from welfare burdens and the aged as a class from medical indigence. At the crucial point, the bill intervenes against medical indigence by insuring against it.

A basic question, therefore, is whether H.R. 4222 does in fact set up an insurance plan. It is quite clear that if all the aged can acquire health insurance, then indeed medical indigence among them will substantially disappear, the general revenues will no longer be burdened by welfare expenditures and private welfare agencies can turn their energies to other forms of aid. But a doubt arises. It would seem that if it were financially feasible for the current aged to buy health insurance, insurance companies would have long ago sold it to them. Consequently one suspects that the plan of H.R. 4222 can hardly qualify for the traditional meaning involved in the term "insurance."

The Real Process of H.R. 4222

If we postpone giving names to things for the moment and ask ourselves precisely what this bill will effectuate, we find the following. The bill would confer on the aged as a class of people a right to defined free medical treatment. It would correspondingly impose on income-earning adults a duty to pay for this medical service out of their current earnings whether the particular aged person could pay for it or not. (There is no financial need test in the bill; age alone qualifies for aid, while the time and money limits are exceptionally liberal — perhaps without effective limits.) Under this bill, to put it at the most illuminating marginal case, a married adult earning $4,500 a year would have to contribute to the expenses of a nine-day hospital sojourn followed by lengthy nursing home care even in the case of an elderly widower living in a $15,000 house and having $25,000 in the bank.

Defenders of the bill will deny this description of it. The denial rests on the assertion that the expenses of the medical care provided will be defrayed by a system of insurance.

The analogy with insurance is accurate enough when it is intended to describe the subjective experience of the aged recipient of free medical aid. For him, it is as if he were enjoying the benefits of private medical insurance. For him, it is as if a health insurance policy were paying off. But the analogy not only breaks down, it is absolutely misleading when applied to the fiscal arrangements behind the payments and when considered in relation to the intentions expressed in H.R. 4222. The analogy, that is to say, breaks down when applied to every aspect of the bill that is relevant to the operational realities involved in it. One massive fact stimulates closer examination of the fiscal realities: if it passed, the 15.6 million aged now living, the 8.8 per cent of the total population, would immediately acquire rights to free medical treatment *without having paid one cent into the program.* This is not the way an insurance program operates.

If we examine more carefully the process the bill sets up, we find it to be a concealed pay-as-you-go system. Trust funds are set up; an impenetrable system of credit transfers is organized. But in essence the annual medical expenses incurred by the bill will be paid off by an assessment on the income-earning segment of the society. The annual assessment character of the process is most evident

*Testimony presented to the U.S. House Ways and Means Committee, July 28, 1961, on the proposed King-Anderson Bill (H.R. 4222), a measure to finance certain limited medical care for the aged through Social Security.

in the lack of all the normal insurance mechanisms. In H.R. 4222 there is no full reserve mechanism. Indeed, apart from bookkeeping credits there is no reserve mechanism at all. The system is not rooted in the principle of prepayment. Following from this the future benefits to be received have no relationship to the amounts paid in. We begin with the 15.6 million existing aged who really get aid free without payment of any kind. From that point on, the system is simply a dependency arrangement: the aged have to depend on younger generations to give them what they in their day gave to the then aged group. To put it most succinctly the payor does not build up an equity through his payments; he acquires no *economic* claim to future medical aid. The entire process is political.

Consequences of the Process for General Revenues

The objection here is not that the fiscal arrangements are unsound because they are based on a political commitment. The real objection is that because the process is essentially political, even in its fiscal aspects, the payment of medical services for the aged must be financed by the taxing process. And from this single fact it follows that none of the objectives of the bill will be realized except the sole one of free medical aid for the aged. To put it more strongly, the bill will further burden the general revenues, it will further burden relief agencies and it will further complicate hospital facilities.

To perceive this one must abandon false categories of analysis and legalistic distinctions, and look at the realities involved. It is generally agreed that government has the authority to compel citizens to pay for the costs of government. The total amount of money the government must extract from its citizens is determined theoretically by the total costs of governmental operations, practically by how much the government can make the citizens stand still for. The process whereby the government gets money is called taxation. Taxes provide the general revenues. Now within the process of securing and spending money the bill distinguishes between general revenues (which are to be freed of burdens) and evidently insurance premiums which the citizens will pay for old age health insurance (generally one half per cent on the first $5,000 of income). In this distinction between taxes and insurance payments we have one of those distinctions without a meaning. Whatever benefits the government supplies, the people have to pay for. Thus they pay for domestic tranquillity, the just solution of legal conflicts, national defense, education, etc. They also will pay for the costs of government financed medical aid to all the aged. The "insurance" payments are in fact taxes earmarked for medical expenses. And one can be sure that this tax will never be reduced and will probably be raised when the medical expenses turn out to be more than was estimated. To consider one set of payments taxes and another set not taxes is to engage in obfuscating semantics. Taxes are what the government takes from the current income of the people by legally sanctioned coercion if necessary. Social Security payments and the proposed H.R. 4222 extension rest on the taxing power. (Cf. Fleming *v.* Nestor, 363 U.S., 1960, for a judicial recognition of this fact.)

From this it follows with an iron necessity that the general revenues of the government, considered as the total amount of money the people pay to government, will not be relieved of burdens. The taxes — the general revenue — expands by one half per cent, and the general burden on the taxpayer increases by about that much.

The people generally are currently bearing the burden of the marginal local relief of medical indigence. What this bill proposes is to add to this burden the further one of paying for the medical needs of all the aged, even of those who can afford to pay for their own. This additional burden on the people, *ergo* on the general revenues, is concealed by the appellation "social insurance."

To perceive more precisely the manner in which this policy adds to the burden of the general revenues, we must advert to the general condition of revenues and taxation. Congress has recently voted to raise the national debt limit. This implies that the collection of money from current income (taxes) has already reached its political limit. The people will not stand still for more, and even if they did, it is probable that further taxes would result in grave economic difficulties and a consequent reduction in revenues. It is already recognized that the tax burden in existence has resulted in vast and unforeseen modifications of our economic and social

continued on next page

One of the most controversial legislative proposals before the Congress is the King-Anderson Bill (H.R. 4222), a measure to finance certain limited medical care for the aged through Social Security.

Reverend Stanley Parry, C.S.C., chairman of the Department of Political Science at the University of Notre Dame, presented one of the most thought-provoking reports on the legislation to the Congressional House Ways and Means Committee at the hearings on the bill last summer. A graduate of Notre Dame in 1941, Father Parry received his Master's degree from Georgetown University, and his Doctorate from Yale University, and he has taught at Notre Dame since 1950.

Because this is an outstanding review of the legislation which will be renewed by the Congress this year, it is being published in the RHODE ISLAND MEDICAL JOURNAL in two parts. This issue carries Part II, *H.R. 4222, As an Insurance Plan*, and Father Parry's general conclusions.

THE EDITORS

life. There is a well-founded suspicion that our economic growth may already be adversely affected by the vastness of the sums taken from the economy. The real consequences of further extending the taxing process under the guise of insurance cannot be indefinitely avoided. In domestic politics it is generally true that what people think is as important as what actually is so. But we deal here with a phenomenon the results of which will work out objectively no matter what misleading categories we may use to think about it. Every additional burden on the income earner now makes it just so much less likely that further burdens will be tolerated. And no amount of confusion about "social insurance" payments lightening the burdens on the general revenues can avoid the truth.

Consequences of the Process for Welfare Agencies

With regard to local welfare agencies it is clear that their financial burdens will be lightened by H.R. 4222. It is less clear that their administrative burdens would (old administrators do not even fade away). However, the essential point here is that the burdens of welfare in general would not be lightened. They would be increased, and increased notably. It is beside the point that HEW is only too happy to bear such burdens. The point is that a federal process would appear in proportions that would vastly overshadow the aggregate of existing local welfare operations. The bill asks the Congress to consider the unlikely situation in which an increase of free medical aid from "many" to *all* the aged would result in a reduction of the burdens of such aid.

Consequences of the Process for Medical Facilities

It is not without significance that there is little agreement on the predicted cost for medical aid this bill would involve. The usual predictions estimate the number of beds, etc., currently used for the aged. To this they add the number that will be needed in addition if all the aged were to receive the medical treatment they need. The result is then considered to be an accurate estimate of the future costs and of the future need for beds, etc. The fallacy here can best be illustrated by the estimate that if it takes one boy two hours to mow the lawn it will take two boys one hour to mow the same lawn. Everyone knows it will take two boys three hours to do the job. For the factor of companionship introduces a behavior-changing element into the picture. So for medical aid, predictions of the use of free medical facilities really involve a projection from how much medicine a man thinks he needs when he pays for it himself, to how much he thinks he needs when it's free. No existing statistics on the use of facilities or on the size of latent real need can be the basis for estimating the greed of man, his willingness to consider himself sick when medicine is free, or the doctor's ability, when the patient does not pay, to conclude that an aged person is just as well off in his own home as he would be in a nursing home. One thing, however, is predictable, although its proportions are not: there will be a noticeable increase in the number of aged sick under the bill, and this number will be larger than the increase if suddenly all the aged could pay for their own real needs. Many people will go to the *hospital* because it is free. Many people will go to nursing homes as often and as long as they can because it is more pleasant there than at home. One can hardly conclude that this will lighten the burdens of existing facilities. One can rather conclude that it will produce a wasteful use of facilities.

PART III

Some General Considerations

If the inadequacies of H.R. 4222 are anywhere near as massive as has been suggested the question inevitably arises: why is such a policy even conceivable? We can concretize the question by asking what set of considerations could conceivably account for the proposal to shift from the marginal relief of medical indigence to total preventive intervention? To answer this question adequately would require a complete analysis of the malaise of modern society. However, a brief characterization of the antithetical points of view on which the two approaches to relief are rooted might serve to put the problem raised by H.R. 4222 in its true context, a context far broader than the statistics and far deeper than any concern with mere money can suggest.

The view of society on which the principle of marginal relief is based has already been indicated. Its fundamental note is that of optimism. There is in it a confidence that the socio-economic order, if only left alone, can achieve ever new and creative solutions to the problems raised by its own operations. For it, the political order exists to police the fringes of that system, to preserve the broad outlines of order, to enforce the basic conceptions of justice that are so central to general order that even the isolated violation of them by individuals cannot be tolerated. This optimism is modified by the realization that the system does not work for every single individual. In such cases, the society offers relief through either public or private aid.

In contrast with this view, the principle of preventive intervention as embodied in H.R. 4222 is rooted in a pessimistic view of the society. It is motivated by the conviction that the system does not work for whole classes of people. And it does

not foresee any conceivable improvement in the operation of the system. In H.R. 4222 the very conception of progress is abandoned. The cost of medical treatment is on the increase; this too is a permanent condition, and it suggests that the indigence of the aged will grow worse by the year. Many of the current aged cannot afford medical treatment; in the future there is no change in this. H.R. 4222 postulates a future where all changes in the condition of the aged are adverse. It looks into a future where the energies of a society busy with the process of living will be unable to surmount the problems it meets.

The ultimate issue H.R. 4222 raises is: which view of society is objectively tenable. If both attitudes were simply matters of emotional responses, neither one would deserve the attention of responsible statesmen. But if the objective evidence available suggests that the optimistic attitude is rooted in fact and the pessimistic one rooted in fear, then the choice of view and policy is clear.

By the objective test, the evidence lies totally in favor of the more hopeful view. Modern industrial society is a relatively recent arrival on the historical scene. Its early days were accompanied by hardship and error. But much of its development was involved in solving the problems of human life in industry as these problems were accurately identified. Industrial society in America early began building into itself solutions to emerging problems. With regard to the aged, our particular case, we see the development of pension plans, the general increase in the capacity to save resultant upon the improved condition of the working man, the rapid development of voluntary insurance, the emergence of co-operative self-help systems. All the existing trends, when projected into the future, suggest only a gradual and general improvement of the condition of the aged. With regard to the cost of medicine, we must note that medical treatment is becoming cheaper as well as more expensive; a good deal of the increased cost is due to the improvement of treatment. The frontiers of medicine will always be expensive and available only to the wealthy. But the law of development is for the unusual and expensive to become ordinary and relatively inexpensive. This works in medicine as well as in technology, for drugs as well as television sets.

Therefore, if in the jungle of statistics some color of title no matter how faint can be found for federal activity with regard to the aged, let it be provided on the basis of the objectively defensible policy. The Kerr-Mills Act offers a good example of properly based federal activity in this area. It uses the grant-in-aid principle to reinforce local welfare activity. And, by retaining the need criterion, it keeps expenditures under control. The objective justification of this activity may be found in two developments characteristic of modern society. First, the mobility of the population can easily result in some localities acquiring responsibility for a disproportionate percentage of the aged. Secondly, the rapidity of technological changes has produced what may be a continuing phenomenon: the soft spot in an otherwise strong economy. Since this soft spot frequently has a geographical as well as a functional location, the need for special aid seems reasonable.

Much wiser and far-seeing than the Kerr-Mills Act, is the bill H.R. 10 that received the blessings of this committee some years ago and was passed twice by the House, although not by the Senate. This bill gets at the problem of old age dependency by encouraging saving for old age on the part of the individual. The essence of its plan is to offer a tax deduction covering up to 10 per cent of income provided it is invested in a manner that provides for retirement years. This provision is intended to stimulate self-help by offering an added motive for foresight. It encourages responsibility and independence. It does not increase the tax burden but lightens it. It is rooted in the confidence that the income earner generally earns enough to save some. It is a model of wise legislation. For instead of imposing an *a priori* plan on the society, it co-operates with and encourages desirable aspects of the ongoing organization.

To do otherwise, to interfere with this development is to kill it. The over-all plan means over-all stasis. Direction from above means inanition below. H.R. 4222 precisely intends to intervene into the development of ever new and creative solutions for the problems of the aged. And it does so precisely because it postulates failure on the part of the society to continue the progress that is currently visible. No amount of statistics can conceal from the fearless eye the clear truth that American economy has achieved a degree of well-being unheard of in the history of man. And no amount of statistics can prove this to the fearful mind.

Ours indeed is an age of crisis. And there is in our times a deep source of insecurity. But that source is not economic. And no amount of state-supplied economic security will ever relieve the anxiety our people are trained to by public policy based on pessimism and rooted in the assumption that things are bad and getting worse. Never before in the history of man has a nation been at once so young, so strong and so fearful. H.R. 4222 offers an opportunity to increase that fear or to begin its conquest.

PATRONIZE JOURNAL ADVERTISERS

Check the Date Now!

CANCER SYMPOSIUM FOR PHYSICIANS

At the Rhode Island Medical Library

Wednesday, March 28, 1962 at 2:00 P.M.

Panel Presentation on

CARCINOMA OF THE COLON AND RECTUM

Panelists

MICHAEL DEDDISH, M.D.
of Memorial Hospital for Cancer and Allied Diseases, New York, New York

GORDON ZUBROD, M.D.
of the National Cancer Institute, Bethesda, Maryland

ALEXANDER MARGULIS, M.D.
of the Edward Mallenckrodt Institute of Radiology, Washington University, School of Medicine, St. Louis, Missouri

Sponsored by the Cancer Committee, Rhode Island Medical Society

---

FOURTH CARDIOVASCULAR SYMPOSIUM FOR PHYSICIANS

Wednesday, March 21, 1962, from 1:45 to 10:00 P.M.

At the Colony Motor Hotel

Panel Discussion:

RHEUMATIC FEVER — DIAGNOSIS, TREATMENT AND MANAGEMENT

Moderator: GENE H. STOLLERMAN, M.D.
Associate Professor of Medicine, Northwestern University Medical School, Chicago, Illinois

Panelists:

CHARLES W. FRANK, M.D.
Department of Medicine, Albert Einstein Medical School, New York, New York

MILTON MARKOWITZ, M.D.
of Baltimore, Maryland

Evening Lecturer: HOWARD B. SPRAGUE, M.D.
Former Lecturer on Medicine, Harvard Medical School

Sponsored by the Rhode Island Heart Association
in co-operation with the Rhode Island Medical Society

Editorials

THE HEALTH FAIR

The Rhode Island Medical Society Sesquicentennial Exposition of Health Progress will open in the Cranston Street Armory on Friday evening, April sixth, and continue through Saturday the fourteenth. As of this writing sixty-five outstanding exhibits have already been received and there will undoubtedly be a few more. The calibre of the Fair has been kept high by rejecting numerous displays that lack vitality or teaching interest. Among those accepted will be such displays as life-size montages of various stages of an appendectomy, a pathology set-up with frozen sections being made, and various push-button devices that will light up models or set apparatus in motion. There will be at least three health careers exhibits. A continuous motion picture theatre will be available for the leg weary.

The Sesquicentennial Committee, as it has learned about fairs in other cities and as it has seen our own develop, has become enthusiastic over the project. Here is the opportunity for Rhode Island physicians to mark their anniversary by doing something worthwhile for the community. The materials for success will be at hand. To achieve it we shall require the expenditure of much time and energy by the profession. During the mornings and early afternoons there will be guided tours for schoolchildren. The limited number of school superintendents already approached hope to send their eighth or ninth grades and we may be handling six hundred pupils an hour. At other times it will be desirable to have as many physicians as possible, preferably one for every booth, to explain and answer questions. Experience in other cities shows that this important participation will make the difference between an average show and a striking success. Let us mark this public celebration of one hundred and fifty years of organized medicine in Rhode Island with an achievement of which we shall all be proud.

HAPPY BIRTHDAY!

Our distinguished contemporary, the *New England Journal of Medicine*, has just celebrated its one hundred and fiftieth anniversary. It is the oldest medical periodical in the English language in continuous publication. The issue of January 4, 1962, Number 1 of Volume 266, was designated as the Sesquicentennial Number. Another more or less distinguished contemporary, the *Harvard Medical Alumni Bulletin*, in rather haughty, if whimsical phrases recently stated with some historical justification: "A fresh breeze, according to the vernacular, stirring about a hundred and fifty years ago, was responsible for a small outbreak of organized efforts at improving health conditions in the north-by-northeastern section of the Atlantic Seaboard at that time. Some of these attempts have been mentioned in previous issues of the *Bulletin* — especially the founding of the Yale University Medical School and of the Massachusetts General Hospital, the elusive dates of their emergence bouncing about like hard peas on a hot griddle — and the more clearly documented establishment of the Boylston Medical Society, the semitercentenary observance of which last May was duly noted. . . ." In its lead editorial *The New England Journal of Medicine* also speaks of Yale Medical School, the M. G. H., and the Boylston Medical Society. With a sidewise glance at its "relatively esteemed contemporary," the *Bulletin* concludes: "Still another sesquicentennial occasion is at hand — that of the founding of the *New England Journal of Medicine*, its roots so deeply embedded in the soil of Boston and its New England environs that an attempt to loosen them would probably shake dirt where least expected. Due homage having been paid to this organizational accomplishment, so stubbornly resistant to complete decay, relief from such festal opportunities may be expected until the quartersexcentenary celebration of the Treaty of Ghent some three years hence"— except for one,

continued on next page

we might add.

With preoccupation typical of a Cleveland Amory dowager, to whom anything west of Dedham could be on the moon, the Sesquicentennial of our own venerable Medical Society to be celebrated in May, long before that of the Treaty of Ghent, is not worthy of notice. It occurs to us incidentally that we missed the bus in a mild way by not celebrating our own journalistic centenary in 1960, this organ having then been in continuous publication since the appearance in 1860 of the first issue of its lively predecessor, The *Communications of the Rhode Island Medical Society*. We might also be tempted to mention another local medical institution which started about that time, the Medical School in Brown University of 1811. It, however, sacrificed some of its justification for notice by going into hibernation for some one hundred and thirty-five years.

We do not mean to detract in the least, however, from the rightful and justifiable pride of our hale and hearty neighbor. The Sesquicentennial was appropriately celebrated on January 13th at a delightful dinner at the Harvard Club in Boston, to which with gracious hospitality this editorial parvenu was invited. Participating in the exercises were Doctor Richard M. Smith, chairman on Publications of the Massachusetts Medical Society, Doctor Joseph Garland, the distinguished and successful incumbent of the editorial chair, and Doctor Wilder Penfield, now honorary consultant of the Montreal Neurological Institute, the guest speaker, who dilated upon *The Serpent and The Quill*. The program and menu card of the evening had on its cover a striking miniature reproduction of the Sesquicentennial Number of the Journal.

For the benefit of our readers who may not have seen that historic issue, we shall recount briefly the pertinent history. In January of 1812 there appeared in Boston a new quarterly with the pretentious title of the *New England Journal of Medicine and Surgery and the Collateral Branches of Science* "Conducted by a number of Physicians." It was founded actually by those two energetic and able young Harvard teachers, John Collins Warren, surgeon, and James Jackson, physician. In 1828 it purchased and combined with the weekly *Boston Medical Intelligencer* established in 1823, and became the weekly *Boston Medical and Surgical Journal* publishing under that famous name for one hundred years. The *Journal* became in 1914 the official publication of the Massachusetts Medical Society, and its property through purchase in 1921. It adopted its present title in 1928.

It is now unquestionably one of the great medical journals of the world. Its charming, humorous, and scholarly editor, Doctor Joseph Garland, deserves no small part of the credit for this healthy and vigorous old age.

We wish to convey to *The New England Journal of Medicine* our heartiest and neighborly congratulations and best wishes for continued good health and a successful long life, yea unto three hundred years!

STANLEY H. SAUNDERS

THE UNTIMELY DEATH of Stanley H. Saunders, executive director of both the Blue Cross plan and the Rhode Island Medical Society Physicians Service, is truly a great loss to Rhode Island. His contributions to the development of the voluntary health insurance movement during the past two decades are monuments to his outstanding executive ability and leadership.

It was in 1929 that the group hospitalization movement was initiated by schoolteachers in Dallas, Texas. That was the same year that Germany's famous Graf Zeppelin made its memorable 19,000 mile around the world flight in 21 days, 7½ hours. The intervening years have seen both Blue Cross, and its sister plan, Blue Shield, rival the tremendous growth of air travel from the zeppelin to the jet plane.

In 1939 the Rhode Island Medical Society and the heads of the hospitals in this state made a lengthy and thorough study of experiments in other areas where group prepaid hospitalization programs had been launched before agreeing to establish such a plan here. Legislative agreements were drafted, outstanding civic leaders joined with the physicians and hospital administrators to work out details, and the Rhode Island Blue Cross was finally started on September 1, 1939.

To head the new organization the directors selected Stanley Saunders, then director of enrollment for the Massachusetts Blue Cross after two years as a district manager for the New York City Blue Cross organization. It is unnecessary to relate the achievement of Mr. Saunders in the past twenty-two years in making Blue Cross and Physicians Service the plans with the highest percentage of the population enrolled of any state-wide plans in the nation, and with the lowest operating expense of any. At the same time he gave liberally of his talents as an active member of many civic organizations, and as a member of national and regional Blue Cross and Blue Shield Committees.

He built a strong organization here in Rhode Island, and he leaves an outstanding staff to carry forward his ideals and objectives. But his unique leadership will not readily be replaced.

MEANS TEST POPPYCOCK

POLITICIANS AND LABOR shed crocodile tears and oppose Kerr-Mills implementation because of its means test. This is pure poppycock. As every informed person knows the means test is now widely used by government and social agencies, and has been accepted by the public without visible resentment. We shall give a few examples where a means test is now used. It is used in Veterans Administration hospitals; in all the numerous welfare agencies whether municipal, state, or federal; in all federal housing projects including the new Weybosset Hill project, designed especially for the aging; in classifying ward and service patients in every hospital in the state; and of course, closest to home, in the application of service benefits in Physicians Service. The most recent application of the means test to reach the news columns has to do with the awarding of state scholarships for higher education.

It is a final irony that the King-Anderson Bill would be administered through Social Security, which, as everyone knows, determines eligibility for payment on the basis of — Yes! — a *means test.*

A VALUABLE PROPERTY

FOR THE PAST twenty-four years we have had in our midst a personality who has become so much a part of the local medical scene that we have come to take him for granted. We refer to our highly efficient man of many jobs, our able and knowledgeable executive secretary, the estimable John E. Farrell. The time is urgently at hand when we should take stock of our situation and look about us.

Toward the end of the 1930's the business of running a medical society had become sufficiently complex and demanding to prompt our leaders of that time seriously to investigate the desirability of engaging a full-time executive secretary. The Providence Medical Association, the largest of our component district societies, took the initiative in this movement. Among the various candidates, one young man above all others stood out as the most promising. He was engaged in June, 1938, for the newly created position of executive secretary of the Providence Medical Association, and has been with us ever since.

Mr. Farrell, "John" to so many of us, had graduated from Providence Classical High School in 1922 and from Providence College with a liberal arts degree in 1926. He became graduate manager of athletics at his alma mater from the time of graduation until accepting his new position. Of particular pertinence to us were his graduate studies in English at Harvard and in journalism at Boston University which led to his teaching of English and journalism at Providence College in addition to his athletic duties.

In his characteristically energetic and systematic way he set about creating the position which he has since filled, in fact, making his job a model for many other medical societies to follow. In 1943 it became obvious that the State Society had even greater need for his talents than did the local group. Consequently an arrangement was made whereby he became the executive secretary of both societies, and in addition the managing editor of the RHODE ISLAND MEDICAL JOURNAL. In 1949 he became executive secretary of the Rhode Island Medical Society Physicians Service as well. Among his *ex officio* duties he is director of the Providence Medical Association's Medical Bureau which he himself organized.

Anyone who has watched Mr. Farrell in action or has been obliged to lean upon his substantial talents well knows what a pervasive influence and a stalwart factotum he has been. We shall review some of his many duties knowing that we risk the omission of many others. He prepares the agenda and records the minutes of all meetings of both the Providence Medical Association and the Rhode Island Medical Society. These include the regular open meetings, the House of Delegates, the Council of the Rhode Island Medical Society, the Executive Committee of the Providence Medical Association, and *all* committees of both societies, a very numerous group indeed. He also is recording secretary for the Board of Directors of Physicians Service. He conducts most of the correspondence of both the Providence and State Societies and is business manager of both, keeping their books, receiving income, and making disbursements. His duties with the medical journal involve solicitation of advertising, make-up, printing arrangements, the writing of editorials, and the keeping of its books.

He is the Society's chief lobbyist on our local Capitol Hill, and an effective informant and wise counsellor regarding the devious ways of politics and politicians. He is our public relations counsel and an effective spokesman to the press and public respecting our views and problems.

John Farrell has become an expert in medical

concluded on next page

politics and policy on the national scene. He attends regularly the annual and interim meetings of the American Medical Association. He has been chairman of the Advisory Committee to the Public Relations Department of the A.M.A. He has become a familiar figure at these assemblies and he is a trusted and respected figure in national councils. His services have, in fact, been sought eagerly in other areas; but he has chosen to stay in Rhode Island where his roots are deep.

In recent months, with mounting harassment from labor and political groups, his duties and responsibilities, and the pressures upon him have multiplied. His wise guidance and instinctive sense of timing have been invaluable in these difficult times. His clear prose and sharp pen have been a great asset to us.

But this is not all. He has given guidance in the organization of the coming Health Fair which was, incidentally, a product of his fertile brain. He keeps two charming and efficient secretaries busy with his mountainous correspondence and writing — finding time besides to dash off letters and copy on his own typewriter. He answers the phone to inform or soothe reporters, and to quiet ruffled patients who are now sure that they have a grievance, because they have read about it in the newspapers. Always courteous and co-operative, he finds time to be helpful to everyone with a problem. Finally he operates the slide projector at meetings. This gives but a meager picture of the duties and activities of this beaver of a man — eager, perhaps, but to the benefit of everyone.

Our purpose in writing this encomium is to draw attention to a serious problem confronting our Society. The numbers of duties to be performed and the complexity of problems to be met have reached a point where one man can no longer cope with them unassisted. The need for help for our executive secretary has become acute and pressing. Despite his youthful appearance and springy step he has attained an age where consideration must be given to relieving him of some of his onerous routine functions. It is now appropriate that we make provision to train a successor and possibly provide additional secretarial help as well, and also to make provision in the unhappy event of incapacitation for the normal operation of the Society's business. With adequate and intelligent assistance our valuable executive secretary would be able to devote greater time and effort where his talents are most needed — in policy-making, public relations and publicity, lobbying, and writing — and perhaps have a few evenings at home with his patient wife, who has seen precious little of him over the years. We most certainly wish John long and continued good health, but a realistic appraisal of our needs requires that provision be made for other exigencies.

We are aware that the inexorable operation of Parkinson's law of administrative reduplication has caught up with us. But this is a defect of our times, and not of our philosophy. The need is here and must be met. The increased costs for this necessary additional service should be and we believe will be accepted cheerfully by the membership of the Society.

Invest in the future health of the nation and your profession

Give to medical education through AMEF

American Medical Education Foundation AMEF 535 N. Dearborn St. Chicago 10, Ill.

E. P. ANTHONY, INC.

Druggists

WILBUR E. JOHNSTON, Phar. D.
RAYMOND E. JOHNSTON, B.S.

178 ANGELL STREET
PROVIDENCE, R. I.
GAspee 1-2512
Pharmacy License #225

J. E. BRENNAN & COMPANY

Leo C. Clark, Jr., B.S., Reg. Pharm.

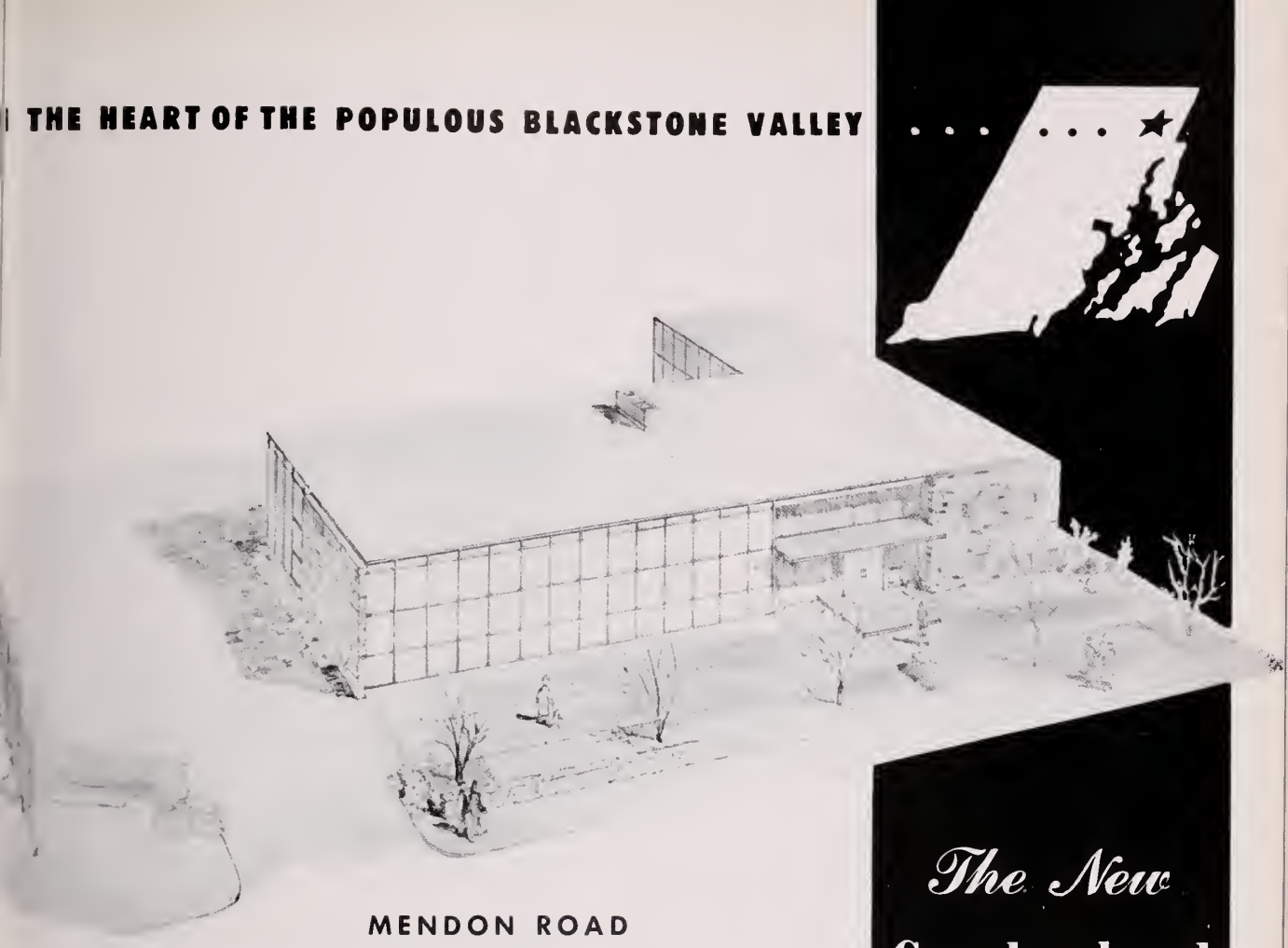
Apothecaries

Two Convenient Locations

5 North Union Street — Pawtucket, R. I.
140 Central Avenue — Seekonk, Mass.

7 Registered Pharmacists
Pharmacy License #226

THE HEART OF THE POPULOUS BLACKSTONE VALLEY



MENDON ROAD

CUMBERLAND • RHODE ISLAND

On Route #122 off the Eddie Dowling Highway
— 20 minutes to downtown Providence

IN these days of an increasingly mobile population, the trend in business is to decentralize . . . to leave the congestion of urban areas that are being choked by traffic . . . and to turn that same traffic to advantage in the wide open spaces of suburbia.

This advantage also accrues to physicians and other professional men who, in ever increasing numbers, are relocating in suburban professional buildings.

The new Cumberland Medical Center will afford this basic advantage, plus several not enjoyed in such profusion in other areas.

Bomb shelter included in the building.

Suites will be available with areas of from 460 to 790 square feet, and will be partitioned to suit the needs of each tenant.

The New

Cumberland Medical Center

For Full Information
Phone
HOMESITE REALTY, Inc.
Agents

PAwtucket 6-5100

EXTRA-UTERINE (ABDOMINAL) TERM PREGNANCY*

A Case Report

HENRY E. TURNER, M.D.

The Author, *Henry E. Turner, M.D., Chief, Department of Obstetrics, the Memorial Hospital, Pawtucket, Rhode Island.*

THIS REPORT concerns this unusual event in a thirty-seven-year-old primigravida seen at Memorial Hospital. Her last menstrual period had been on September 24, 1953, and her estimated date of confinement was June 30, 1954. The patient was referred to us by her family physician on July 14, 1954, two weeks past her due date. There were signs of mild pre-eclampsia present at that time. She was admitted to the hospital, not in labor, but for observation and treatment of the pre-eclampsia.

Roentgenograms were taken for soft tissue study because of unengagement of the presenting part and clinical evidence of a transverse position of the fetus. These studies did not reveal any abnormal masses, but the vertex was found to be in the right flank with the fetal spine transversely across the maternal abdomen.

The day following admission, July 15, a sterile vaginal examination was done; the cervix was found to be thick, soft, anterior, and undilated. There was a mass present, which was felt to be in the right lower segment near the cervix. A tentative diagnosis of a leiomyoma of the uterus was made which was felt to be causing the malpresentation.

That same day, the patient was taken to the operating room for a Caesarean section. A synopsis of the operative findings follows:

On opening the peritoneum, a sero-fibrinous fluid was noted, at this time, small bowel was observed crossing the superior, anterior portion of the conceptus; it was reddened, but viable and easily freed with no bleeding. On palpation of the conceptus mass, the brownish, necrotic-appearing sac ruptured, and a small amount of amniotic fluid was expelled. This rupture was then extended with the bandage scissors, and a normal fetus delivered with no difficulty.

The placenta was found to be implanted on the fundal and posterior wall of the uterus, exteriorly, extending onto the posterior parietes in the culde-sac. Thus, the uterus was actually posterior to the products of conception. The uterus was the mass previously felt on rectal and vaginal examination, but was not delineated at the time from the product of conception. The placenta looked and felt thick, yellow, and fatty.

On palpation, the placenta began to free up easily, therefore, the placenta was removed, there being no vital organs involved in its attachment. Small shreds of villi remained which left oozing areas. These were clamped and tied. The area posterior to the uterus and the pouch of Douglas were then packed with three large packings for hemostatic purposes. The abdomen was then closed in the usual manner, except where the three packings extruded through the incision. The patient received a total of four transfusions as the blood loss was greater than the usual amount found at routine Caesarean sections.

The post-operative course was similar to that of the usual Caesarean section. The temperature, pulse, and respiration were not remarkable. Six days later, the patient was taken to the operating room, and the three packings removed with care and trepidation. At this time, sero-sanguinous fluid escaped, but there was no bright red or brisk bleeding. The former site of the implantation was carefully observed for excessive, brisk bleeding, but there was only slight oozing at this time. This area had regressed in size and three large pieces of Gel-foam® were inserted for hemostasis. The abdomen was then closed except for a rubber drain which was removed 24 hours later. Again, the post-operative course was uneventful, except that there was no vaginal discharge at all noted until 10 days post-operative to the primary operation. At this time, there was discharged per vaginam, a fibrinous, yellow mass which was reported by the pathologist as a decidual cast. Then the patient discharged normally as in normal delivery or post-operative delivery. A superficial thrombophlebitis of the left leg developed two weeks post-operative with no complications thereof. The patient was discharged from the hospital 19 days after laparotomy, taking home a normal infant, which weighed 8 lbs. and 8 oz. at birth.

*Presented at the Annual John F. Kenney Clinic at Memorial Hospital, Pawtucket, Rhode Island, October 25, 1961.

Comments

The rarity of reports in the literature concerning viable ectopic pregnancy is noted. Hillman and Simon[1] in 1935 collected from all available sources 316 cases of extra-uterine term pregnancy. In this group 158 fetuses were considered viable, and 215 mothers survived. There were 80 cases in which both mother and infant survived. Thirty of these latter infants showed no evidence of neurological or mental disturbances. In other words in 50 per cent of cases fetuses are viable; in 66 per cent mothers survived; and in 25 per cent both mother and baby survived. Suter and Wichser[2] in 1948 reported that one fourth of cases beyond the fifth month produce viable babies, but one third of these will have major or minor deformities, and one half of these will survive eight days or more. Broomes[3] in 1951 added twenty-one cases to the literature occurring over a fourteen-year period after 1935. Of these, eight fetuses were already dead at operation, two died within twenty-four hours, and two of the remaining five showed evidence of neurological disturbance. There were five maternal deaths and only five cases in which both mother and baby survived.

The management of the placenta poses the major problem in this condition. The trend now favors leaving it *in situ* to become absorbed or calcified and, possibly at a later date, removed. The literature to date reveals that the outcome in either method of management is satisfactory. It is essential, of course, to leave the placenta undisturbed when it is attached to some vital organ such as the liver, spleen, or aorta. The placenta is now regarded as an autogenous mass, which is absorbable and can be left *in situ*; but 40 per cent of those left behind at laparotomy developed complications, such as sinuses, peritonitis, and intestinal obstruction. Late removal of unabsorbed placenta has been reported and one case of hemorrhage from a vascularized placenta 56 days after operation.

Respecting the management of packings for hemostasis, a review of the literature reveals little concerning the optimal time of removal. In our case, the packings were removed on the sixth day with only slight oozing from the former site of the placenta.

Our patient experienced during the sixth week of her pregnancy severe abdominal pain in the right side, which became generalized. There was never any vaginal bleeding. This pain was characterized by its aggravated intensity on changing position of the patient or by motion of the bed. This apparently indicates peritoneal irritation due to blood in the abdomen at the time of a tubal rupture, or tubal abortion. It is felt that this history is consistent with a secondary abdominal pregnancy.

References

[1]Heilman, A. M., and Simon, H. J.: Full Term Intra-abdominal Pregnancy. Am. J. Surg., 29:403, 1935

[2]Suter, M., and Wichser, C.: The Fate of the Living Viable Babies in Extrauterine Pregnancies. Am. J. Obstet. & Gynec., 55:489, 1948

[3]Broomes, E. L. C.: Full Term Abdominal Pregnancy with Delivery of a Living Child. Report of a Case and Review of the Literature. J.A.M.A., 145:399, 1951

SCANNING THE MEDICAL LITERATURE

GENETICS AND OCCUPATION by Francesco Ronchese. In: DE GENETICA MEDICA by L. Gedda. (A seven volume treatise on Genetics) Edizioni Dell' Istituto "Gregorio Mendel," Rome, Italy, 1961. Vol. 3.

Diseases known to be hereditary are often occupational hazards. A physician who is aware of such hazards may be able to give proper advice to persons suffering from such diseases. But after a primary irritant has aggravated a pre-existing eczema, for example, it is often too late for a physician to offer advice, and difficult for a person to change his occupation. Thus a constitutional (hereditary) disorder may considerably reduce the earning power of a worker or even totally disable him.

Discussed and illustrated, in twenty-six color and forty-one black and white pictures, are: epidermolysis bullosa, psoriasis, eczema, hypertrichosis, ingrowing hairs, poliosis, common baldness, hyperhidrosis, obesity, peripheral vascular sympathetic disorder of the fingers, acne vulgaris, hidrosadenitis, cheilitis, palmar erythema, palmar and plantar keratoma, diseases of the nails, ichthyosis, dermofragility (Ehlers-Danlos syndrome), xeroderma pigmentosum, ichthyosiform erythrodermia, porphyria, vitiligo.

Sesquicentennial Celebration Dates
SCIENTIFIC MEETING
May 8 and 9, 1962

MENINGIOMA WITH BONE DESTRUCTION

José M. Ramos, M.D., and Donald B. Fletcher, M.D.

The Authors. *José M. Ramos, M.D., Senior Physician, Newport Hospital, Newport, Rhode Island. Donald B. Fletcher, M.D., Chief, Department of Radiology, Newport Hospital, Newport, Rhode Island.*

Meningioma is most commonly associated with a localized area of increased density in the cranial vault or skull base giving a characteristic X-ray appearance. This finding has come to be identified with meningioma and the relationship is so striking that other types of bone change do not call to mind the possibility of this diagnosis.

Cushing, in his famous *Monograph on Meningioma* (1938) described the various effects which meningiomas have on the bone of the skull. As noted above, the most common type is that in which there is a hyperostosing process. In some cases there is thinning of the bone due to pressure absorption, and in an occasional instance there will be no effect upon the bone at all. He mentioned that an extremely uncommon reaction is that in which the central core of the hyperostosed bone is fully destroyed producing the effect on X-ray examination of a solitary bone cyst. It is with this type of process that this paper is concerned.

The following case report we feel is of particular interest because of its rarity and because of the diagnostic problems raised by the unusual X-ray findings. In this respect it might be noted that several neurosurgeons rejected the diagnosis of meningioma when reviewing the films in this case.

Case Report

Mrs. R. T., a colored female, aged fifty-seven, was admitted to the hospital on January 21, 1960, with a history of severe, lancinating, occipital pains, lasting about 5 to 10 minutes, whenever she coughed, laughed, or strained at stools. Otherwise she stated that she had no headaches or discomfort, that her vision was perfectly normal, that she felt no nausea, and was able to walk with no sense of imbalance.

She admitted that she had had a fall during her childhood and had struck the back of her head rather violently, but had never suffered any sequelae from this episode.

She had had a cholecystectomy in 1945 for chronic cholecystitis, an excision of a lipoma of the back of the neck in the same year, and another lipoma of the back of the neck in the same year, and another lipoma removed from her back in 1950.

On admission she appeared in no definite distress. Her temperature was 99.4, pulse 72 and regular, and her respirations were normal with good thoracic excursions. There were no evidences of any skull deformity or bone depressions, either at the occiput or elsewhere.

Her pupils were round and equal, reacting well to light and accommodation. Ocular movements were normal with no evidence of paralysis of either superior, inferior, or medial recti muscles. The eye grounds were normal with no evidence of papilledema. There was no nystagmus. The patient did not complain of vertigo or giddiness, her gait was normal and at no time did she suffer ataxia.

The cranial nerves were intact. Her tendon reflexes were normal with no evidence of a pendular knee jerk. There was no sign of dysmetria or adiadochocinesis. Examination of the ears, nose and throat were noncontributory and the same was true for her general system review.

X-ray studies of the skull on admission (Figures 1-3) showed a discrete 2 cm. cystic rarefaction of the right side of the occiput. There was an increase in density of the bone adjacent to the cyst, and in one view the inner table appeared thinned and displaced forward. No posterior expansion was demonstrated. The examination was negative for evidence of fracture or pressure changes. The pineal was not calcified, and no abnormal intracranial calcification was seen. The sella turcica was not remarkable.

The possibility of osteitis fibrosa cystica was entertained, and X-rays of the long bones gave negative results. Her twenty-four-hour urinary calcium excretion was normal, and a scout film of the abdomen revealed no evidence of kidney stones. A gastrointestinal series was also performed at the time to disclose a possible duodenal ulcer, frequently found in cases of hyper-parathyroidism. This was also negative.

Blood studies on admission showed: 13.0 gms. of hemoglobin, red blood cell count 4.65 million, white blood count, 6,100 with 62 per cent polymorphonuclear leukocytes, 31 lymphocytes, 1 per



FIGURE 1



FIGURE 2



FIGURE 3

cent monocytes, and 6 per cent eosinophils. Her hematocrit was 41 per cent. Her C-reactive protein was 1.4, blood urea nitrogen 12.0 mgm. per cent, total serum protein 6.8 grams per cent (albumin 4.6 and globulin 2.3). Her fasting blood sugar was 80 mgm. per cent, her serum sodium 145, potassium 4.1, and chlorides 103. The serum calcium was 8.6 mgm. per cent, inorganic phosphorus 4.3 mgm. per cent, and alkaline phosphatase 2.5 units.

At this point the diagnosis of eosinophilic granuloma was entertained, and exploration of the lesion was decided upon in order to determine its histological nature.

A suboccipital craniotomy was done at the center of the cystic lesion under sodium pentothal-anectine anesthesia with intubation, and upon removal of the bone button a solid tumor was encountered, grayish-brown in color, invading the bone and bleeding profusely after biopsy.

The tumor was described by the pathologist as a meningioma of the posteriora fossa. Definitive resection was decided upon at a second stage procedure with adequate volume of blood on hand and appropriate instrumentation.

At the second operation the tumor, after careful dissection, was found to be 6 cm. in greatest diameter lying to the right of the midline, extremely friable and vascular, and attached to the occipital sinus. The cerebellar tissue was markedly engorged and distorted in its normal architecture.

The tumor was removed in toto with very little bleeding from the tumor bed, most of it having come from the occipital sinus.

The tumor apparently arose from the dura of the posterior fossa invading the bone and the meninges.

A large piece of gelfoam was used to close over the exposed cerebellum, and tight closure of the galea aponeurotica along the margin of the scalp flap was carried out.

The patient's recovery was uneventful.

HAVE YOU CHECKED

THE DATES?

Sesquicentennial Meeting

at

Brown Gymnasium

MAY 8 and 9, 1962

A STUDY OF SURGERY, UROLOGY, AND PROCTOLOGY

A Report Developed by the National Disease and Therapeutic Index, and Prepared by Lea Associates, Inc., of Flourtown, Pa.

What Is N.D.T.I.?

ORIGINATED IN 1956, the National Disease and Therapeutic Index (N.D.T.I.) is a unique research project designed to provide a continuous flow of reliable, basic facts on private medical practice in the United States. Each of a panel of more than 1,200 physicians reports on all private patient contacts occurring during a forty-eight-hour period once each quarter of the year. Reporting physicians serve voluntarily for a period of four quarters.

Since names are selected randomly, every private practitioner in the country has an approximately equal chance of being asked to participate. Panel members are drawn from forty-eight states and include representatives of all physician specialties engaged primarily in private practice. Great care is taken to insure proper specialty-geographical representation and reporting coverage throughout 365 days of the year.

In return for the invaluable co-operation of individual reporting doctors, data on morbidity, patient and physician characteristics, and general areas of therapy are made available to the profession. Regular quarterly reports are issued to state, county and specialty medical associations, as well as to journals and medical schools. Additional information, beyond the regular reports, is available in the form of special tabulations given without charge upon request.

N.D.T.I. is supported financially by more than a dozen major pharmaceutical manufacturers. (A list of subscribers is available to anyone interested.) The pharmaceutical companies employ N.D.T.I. data primarily in the research and development area as a means of evaluating the need for new compounds which have demonstrated certain pharmacologic actions. Use of N.D.T.I. for advertising or publicity purposes is expressly prohibited by the subscriber contracts.

NDTI

Medical Director
GEORGE MORRIS PIERSOL, M.D., M.A.C.P.
Formerly Dean, Graduate School of Medicine
University of Pennsylvania

Medical Adviser
GUNNAR GUNDERSEN, M.D., F.A.C.S., F.I.C.S.
Past President
American Medical Association

Advisory Committee of Physicians and Educators
J. MURRAY KINSMAN, M.D., F.A.C.P.
Dean, School of Medicine
University of Louisville
KARVER L. PUESTOW, M.D., F.A.C.P.
Professor of Medicine
University of Wisconsin Medical School
FRED MACD. RICHARDSON, M.D.
Director, Continuation Education Committee
Pennsylvania Hospital
EDWARD C. ROSENOW, JR., M.D., F.A.C.P.
Executive Director
American College of Physicians
GEORGE A. WOLF, JR., M.D., F.A.C.P.
Executive Director
Tufts—New England Medical Center

Advisory Committee of Medical Society Executives
WILLIAM H. BARTLESON
Executive Secretary
Jackson County (Mo.) Medical Society
JOHN E. FARRELL, SC.D.
Executive Secretary
The Rhode Island Medical Society
JOHN HUNTON
Executive Secretary
California Medical Association
RICHARD I. NEVIN
Executive Officer
The Medical Society of New Jersey
RUSSELL F. STAUDACHER
Executive Director
Student American Medical Association

The Sample

This report, the third of a series on different branches of private medical practice, focuses on the specialties of SURGERY, UROLOGY, and PROCTOLOGY. In presenting a profile of the specialists' practice, told in certain statistical facts, appropriate comparisons are made with general practitioners and other types of specialties.

According to 1961 figures of the American Medical Association, there are over 22,000 surgeons, 3,200 urologists, and 600 proctologists in private practice in the United States. Included under the surgeon heading are general surgeons, orthopedic surgeons, neurological surgeons, thoracic surgeons, and plastic surgeons. Combined, surgeons, urologists, and proctologists comprise approximately 14% of all private practitioners.

This report reflects data collected during the full year 1960. Figures are based upon the following:

Surgeons	13,900 N.D.T.I. patient contacts
Urologists	3,200 N.D.T.I. patient contacts
Proctologists	800 N.D.T.I. patient contacts

Patient Load

Surgeons, urologists and proctologists (combined) saw an average of 16.8 patients per work day during 1960. General practitioners averaged over 5 more patients per work day.

The regional variation in the surgeon/urologist/proctologist daily patient load ranged from 18.1 (South) to 13.2 (West). General practitioners, by comparison, have a regional range from 23.5 (South) to 19.7 (Northeast). The South region had the highest patient per work day averages for both general practitioners and the surgeon/urologist/proctologist combination.

With regard to the particular specialties, surgeons averaged 17.1 patients per work day; urologists, 15.4; and proctologists, 17.5.

PERCENTAGE OF PATIENTS SEEN BY LOCATION
N.D.T.I. – 1960

	Surg.	Urol.	Proct.	All M.D.s
Office	60%	70%	80%	74%
Hospital	37	28	18	17
Home	2	1	1	6
Other	1	1	1	3
	100%	100%	100%	100%

Surgeons saw almost 2 out of every 5 (37%) patients in the hospital and 3 of every 5 in the office. As might be expected, surgeons had the highest percentage of hospital patients among the major private practicing specialists. Gastroenterologists were second to surgeons in hospital patients (32%) and urologists ranked third (28%). Surgeons, urologists, and proctologists all had higher percentages of hospital patients than the average for all M.D.s (17%) and general practitioners (13%).

PERCENTAGE OF PATIENTS SEEN BY SEX
N.D.T.I. – 1960

	Surg.	Urol.	Proct.	All M.D.s
Male	46%	64%	47%	41%
Female	54	36	53	59
	100%	100%	100%	100%

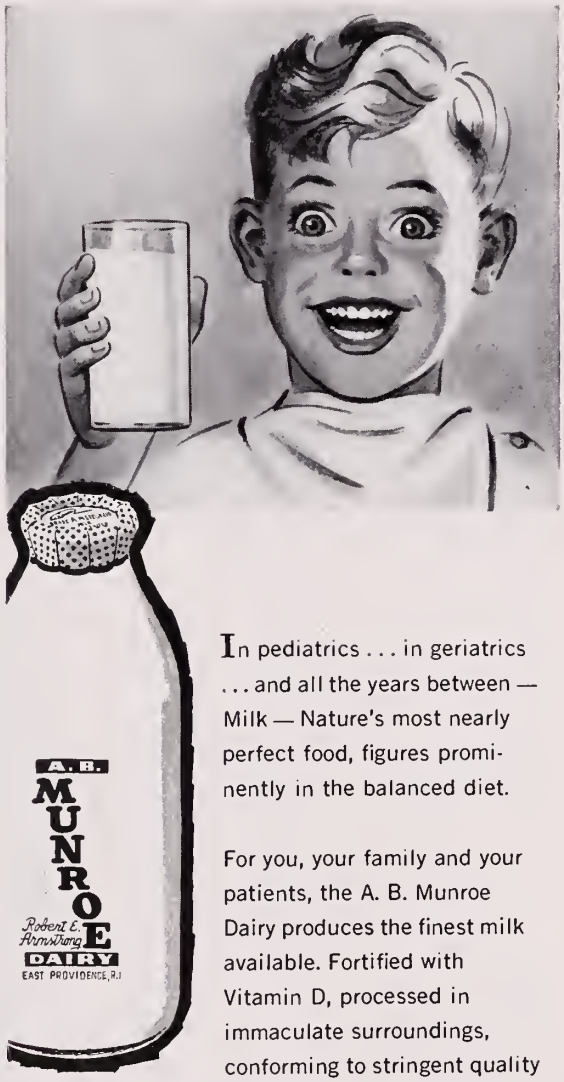
Surgeons, urologists, and proctologists saw a greater percentage of male patients in comparison with the sex distribution for all physicians. Urologists had the highest percentage of male patients of all private practitioners. Only urologists (64%) and allergists (53%) saw more male than female patients.

DISTRIBUTION OF PATIENTS SEEN BY AGE
N.D.T.I. – 1960

	Surg.	Urol.	Proct.
Under 4 Years	5%	2%	1%
4-12 Years	6	2	
13-19 Years	7	3	1
20-39 Years	26	21	28
40-59 Years	35	33	44
Over 59 Years	21	39	26
	100%	100%	100%

continued on next page

"your very good health"



In pediatrics . . . in geriatrics . . . and all the years between — Milk — Nature's most nearly perfect food, figures prominently in the balanced diet.

For you, your family and your patients, the A. B. Munroe Dairy produces the finest milk available. Fortified with Vitamin D, processed in immaculate surroundings, conforming to stringent quality requirements, A. B. Munroe milk is the ultimate in purity and safety.

MODEL HOME QUALITY MILK ASSOCIATION MEMBER

A. B. MUNROE DAIRY, INC.
151 Brow Street, East Providence, Rhode Island

Call GE 8-4450
for Home Delivery

Patients over nineteen years of age accounted for more than 8 of every 10 patients seen by surgeons and 9 of every 10 for urologists and proctologists. By contrast, 7 of every 10 general practitioner patients were in this same age group.

The above table shows that patients over thirty-nine accounted for 70% or more of the urologists and proctologists patients, compared to 56% for surgeons. Almost 40% of the urologists patients were over 59 years of age.

DISTRIBUTION OF DIAGNOSES PER PATIENT
N.D.T.I. – 1960

	Surg.	Urol.	Proct.
One diagnosis	88%	86%	83%
Two diagnoses	11	13	15
Three or more diagnoses	1	1	2
	100%	100%	100%

In keeping with most other private practicing physicians, less than 20% of the patient visits to surgeons, urologists, and proctologists involved more than one diagnosis.

NUMBER OF REFERRED DIAGNOSES
N.D.T.I. – 1960

	Surg.	Urol.	Proct.
Referred from other M.D.s	44%	68%	44%
Non-referred	56	32	56
	100%	100%	100%

More than 2 of every 5 (44%) diagnoses treated by surgeons and proctologists were the results of referrals from other physicians. Urologists had the highest percentage (68%) of referred diagnoses in the N.D.T.I. study during 1960. The only other private practicing specialty with over 50% of the diagnoses referred were the psychiatrist-neurologists with 66%.

PERCENTAGE OF PATIENT-DOCTOR CONTACTS INVOLVING SURGERY
N.D.T.I. – 1960

	Surg.	Urol.	Proct.
Surgery	10%	6%	7%
Non-surgery	90	94	93
	100%	100%	100%

As might be anticipated, surgeons had more patient-doctor contacts involving surgery (10%) than any other type of private practicing physician. The N.D.T.I. includes only non-minor types of surgery and the surgery must have actually occurred *during* the particular patient-doctor contact reported. Much of a surgeon's patient-doctor contacts involve surgical aftercare and are obviously not recorded as "surgery" occurring during that contact, even though surgery may have been performed for that patient at an earlier time. The N.D.T.I. indicates that 1 of every 10 patients seen in a surgeon's day involves surgery during that particular contact.

The three tables below rank the leading individual diagnoses for surgeons, urologists, and proctologists separately. The diagnosis classification is based on the World Health Organization codes. A rate is shown for each diagnosis, representing the number of such diagnoses reported for each 1,000 patient-doctor contacts.

The leading diagnosis for both surgeons and urologists during 1960 was medical and surgical aftercare (for some particular condition). Hemorrhoids was the leading diagnosis for proctologists, with medical and surgical aftercare ranking second. The second ranking diagnosis for urologists was prostatitis, which helps explain the high percentage of male patients for urologists.

LEADING SPECIFIC CONDITIONS TREATED BY SURGEONS
N.D.T.I. – 1960

Diagnosis (rank order)	Diagnosis Per 1,000 Patient Visits
Medical and surgical aftercare	160.3
Follow-up examination after disease, injury, or operation not needing further medical care	59.8
Sprains and strains of the back (including sacro-iliac)	22.8
Hernia of abdominal cavity without mention of obstruction	19.5
Synovitis, bursitis, and tenosynovitis without mention of occupational origin	16.5
Fracture of radius and ulna	13.4
Acute upper respiratory infections of multiple or unspecified sites	13.1
General medical or special examination	13.1
Diabetes mellitus	12.1
Essential benign hypertension	12.0
Cholelithiasis	11.4
Open wound of fingers	11.1
Fracture of neck or femur	10.9
Displacement of intervertebral disc	10.7
Varicose veins of lower extremities	10.7
Ulcer of duodenum	10.4
Hemorrhoids	10.3

LEADING SPECIFIC CONDITIONS TREATED BY UROLOGISTS
N.D.T.I. – 1960

Diagnosis (rank order)	Diagnosis Per 1,000 Patient Visits
Medical and surgical aftercare	131.7
Prostatitis	127.8
Cystitis	102.2
Hyperplasia of prostate	81.5
Urethritis (non-venereal)	77.9
Stricture of urethra	61.5
Follow-up examination after disease, injury, or operation not needing further medical care	54.5
Calculi of kidney and ureter	44.1
Miscellaneous diseases of bladder[1]	33.5

Infections of kidney	31.6
Malignant neoplasm of prostate	22.2
Miscellaneous diseases of male genital organs[2]	17.9
Malignant neoplasm of bladder, urachus, urethra	17.3

LEADING SPECIFIC CONDITIONS TREATED BY PROCTOLOGISTS
N.D.T.I. – 1960

Diagnosis (rank order)	Diagnosis Per 1,000 Patient Visits
Hemorrhoids	344.0
Medical and surgical aftercare	216.7
Follow-up examination after disease, injury, or operation not needing further medical care	151.2
Miscellaneous diseases of intestines and peritoneum	73.8
Anal fissure and fistula	70.2
Pruritus and related conditions	67.9

[1]Includes such diagnoses as male hernia, rupture, ulceration, paresis, paralysis of bladder.

[2]Includes such diagnoses as torsion of testicle or epididymis, male climatric, spermatocele, atrophy of testicle.

Regional Sources of Financial Aid to Medical Students

There are three regional organizations in the United States which have been very active in developing programs to aid needy medical students.

For New England:

The New England Board of Higher Education (NEBHE)
31 Church Street, Winchester, Massachusetts

"If you are a resident of Massachusetts or Rhode Island, your state can help you in securing a medical education through a program developed and administered by the New England Board of Higher Education. In an endeavor to provide expanded opportunities for medical education for New England students, the Board has developed a contractual arrangement between the states of Massachusetts and Rhode Island, and the University of Vermont College of Medicine, under which places are held for residents of the contracting states and the states pay a share of the cost of the students' education.

"How does this system work? A student from Massachusetts or Rhode Island who has been offered admission to the University of Vermont College of Medicine will receive a residency certificate which he will fill out in order to establish his eligibility for the program. The certificate is then forwarded to the headquarters of the New England Board of Higher Education for processing. If found to be a bona fide resident and accepted by the University of Vermont Medical College, the student is automatically under the program. In this case the school charges the lower resident tuition rather than the nonresident tuition fee. The student's own state pays a supplementary fee to the medical school to help meet the cost of providing his medical education.

"It is anticipated that the states of Maine and New Hampshire will also enter into similar contractual arrangements with the University of Vermont Medical College for the coming academic year."

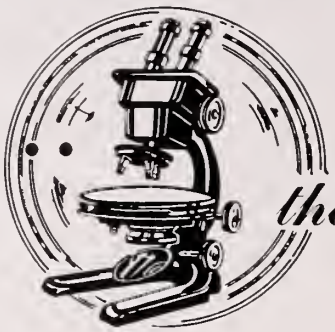
For Rhode Island:

1. Rhode Island Higher Education Assistance Corp.
   199 Promenade Street
   Providence 8, R. I.
2. Rhode Island State Scholarship Program
   Roger Williams Bldg.
   Hayes Street
   Providence, R. I.



Coca-Cola, too, is compatible with a well balanced diet. As a pure, wholesome drink, it provides a bit of quick energy ... brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE-MARK ®

THROUGH . . .  *the Microscope*

R.I. Blue Plans Report New Highs in Enrollment

The Rhode Island Blue Cross and Physicians Service plans both recorded membership gains and new highs in enrollment by the end of 1961, it was announced last month by Arthur F. Hanley, acting executive director of the plans.

Blue Cross membership showed a net gain of 2,136 members over the previous year, for a new high of 647,534 persons covered at the end of the year. The plan enrollment represents approximately 80 per cent of the state's total eligible population, it was stated.

Physicians Service membership rose by 7,677 persons, for a new high of 585,580 Rhode Islanders enrolled, which is about 70 per cent of the eligible state population.

"These gains — during a year in which we had no direct enrollment campaign — demonstrate the continuing public confidence in the plans to provide the greatest return in benefits for the subscriber's dollar," Mr. Hanley asserted.

Mr. Hanley pointed out that 146 new groups were enrolled during the year, and that a total of nearly 3,000 Rhode Island companies now make Blue Cross-Physicians Service membership available to their employees.

The number of firms purchasing Blue Cross for their employees increased by 58, for a total of 1,781 companies. Firms purchasing Physicians Service coverage for employees rose by 268 companies for a total of 1,589.

The plan statement also disclosed that 293 companies, representing more than 53,000 members, increased their level of Blue Cross benefits during the year, such as changing to the full semiprivate Blue Cross Plan.

In addition, 13,686 more persons enrolled under the Physicians Service Plan B, which provides greater surgical-medical benefits, during the year. A total of 148,051 persons are now enrolled under Plan B.

Both the Blue Cross and Physicians Service enrollment records are the highest of any state in the nation, based upon the percentage of the population enrolled.

Nationally, Blue Cross enrollment now totals over 56 million persons and Blue Shield membership is more than 48 million.

Doctor Elihu Saklad Named Chief Anesthesiologist

Elihu Saklad, M.D., has been appointed chief anesthesiologist in the Department of Anesthesiology at the Rhode Island Hospital, to succeed Meyer Saklad, M.D.

Doctor Elihu Saklad was appointed assistant anesthetist at Rhode Island Hospital in October 1937 and served in that capacity until December 1939 when he was appointed senior assistant anesthesiologist — an appointment he has served until the present time.

He is a graduate of Tufts University School of Medicine (1931), a diplomate of the American Board of Anesthesiology and a member of the American Society of Anesthesiologists.

Pleasure $$s Are Double Medical

The American public is spending nearly twice as much money for recreation, alcoholic beverages, and tobacco as it is for medical care, the Health Insurance Institute reported this month.

Out of every dollar the public spends, more than 11 cents goes for the combined costs of recreation (5.9 cents), alcohol (3.0), and tobacco (2.3), while 5.9 cents is spent for medical care, said the Institute in a report based on personal consumption expenditure figures compiled by the U. S. Department of Commerce.

These figures show that in 1960 Americans spent $329 billion on their personal needs. Of this total, $19.6 billion was spent on medical care.

Recreation expenditures amounted to $19.4 billion, $9.9 billion was spent on alcoholic beverages, and tobacco accounted for $7.5 billion, for a total of

$36.8 billion on these three items, or 11.2 per cent of all personal consumption expenditures, said the Institute.

Other personal expenditures in 1960 included more than $70 billion for food, some $42 billion for housing, and nearly $34 billion for clothing, accessories and jewelry.

Taken as a proportion of all personal spending, medical care expenditures have not increased sharply in the past 20 years, especially when the great progress made by medical science is taken into consideration, said the Institute.

In 1940, the public spent $71.9 billion for its personal needs, including $3.0 billion, or 4.2 per cent of the total, on medical care, compared to 1960's 5.9 per cent.

2,500,000 Peptic Ulcers

Some two and a half million Americans have peptic ulcers, according to *Patterns of Disease*, a Parke, Davis & Company publication for physicians. "Within little more than 20 years, estimated prevalence of peptic ulcer in the population has risen almost 6-fold." However, part of this rise, *Patterns* explains, has been attributed to improved diagnostic accuracy.

Citing statistics of the Public Health Service, *Patterns* says, "As a cause of death, peptic ulcer, i.e., ulcer of stomach and duodenum, was ranked as sixteenth in the United States in the year 1959."

Duodenal ulcer occurs three to four times more often among men than women, and gastric ulcer about twice as often. The disparity decreases in older groups, especially after age 45, though in no age group is the incidence among men less than twice that among females. At ages 25-34, for every woman with a peptic ulcer there are about 4 men with a peptic ulcer. The ratio of males to females drops to 3.1 :1 at ages 35-44; 2.3 :1 at ages 45-54; 2.7 :1 at ages 55-64; 2.5 :1 at ages 65 and older.

Although popularly believed to be a young man's disease, peptic ulcer "has been diagnosed in the past ten years with increasing frequency in females and, in a study of peptic ulcer in patients over 60 years of age, 45% presented first symptoms of the disease after age 55," according to *Patterns*. "In the experience of 1 gastroenterologist, incidence of peptic ulcer in children presenting complaints of abdominal pain has increased from 6% before 1955 to almost 20% in the period 1955-60," *Patterns* adds.

Another popular belief — that peptic ulcers are more common among city residents than among persons living in the country — is contradicted by statistics cited by *Patterns*. In rural farm areas, the incidence per 1,000 population is 16.7, in rural nonfarm areas 14.1, and in urban areas 14.

continued on next page

PEDIATRIC TEACHING ROUNDS
Conducted by
Staff of Children's Medical Center, Boston
at
ROGER WILLIAMS GENERAL HOSPITAL

March 2 . . . PEDIATRIC CARDIOLOGY
ALEXANDER NADAS, M.D.

March 16 . . . ERYTHROBLASTOSIS
FRED ALLEN, M.D.

April 6 . . . HEAD INJURIES
JOHN SHILLITO, M.D.

April 20 . . . PEDIATRIC ALLERGY
HARRY L. MUELLER, M.D.

May 4 . . . VIROLOGY
SAMUEL KATZ, M.D.

May 18 . . . CONTAGIOUS DISEASES
R. CANNON ELEY, M.D.

June 1 . . . DENTAL PROBLEMS IN CHILDREN
PAUL LOSCH, M.D.

June 15 . . . FOOT PROBLEMS IN PEDIATRICS
ARTHUR TROTT, M.D.

TESTIMANIMAL



Flavor to crow about!

WARWICK CLUB
GINGER ALE

It sings in the glass



Health Insurance Enrollments and Benefits at New High

In 1961, the health insurance business reached new highs both in the number of persons covered and in the amount of benefits paid out, the Health Insurance Institute reported recently in a review of the past year.

The Institute estimated that as of Dec. 31, 1961, some 136 million persons — or 75 per cent of the civilian population — were protected by some form of health insurance, an increase of four million over the record figure of 132 million reached in 1960.

The Institute also estimated that benefit payments during 1961 totaled $6.3 billion, an increase of about 11 per cent over the record $5.7 billion paid out in 1960.

Another important development during 1961 was the swift expansion of health insurance coverage among older people, declared the Institute.

In addition to the 136 million protected against the cost of hospital care at the end of last year, it was estimated that 124 million persons had surgical expense insurance, 91 million had regular medical expense insurance, 35 million had major medical insurance provided by insurance companies, and 43 million had loss of income protection.

The 1960 year-end figures showed 132 million persons had hospital insurance, 121 million had surgical insurance, 87.5 million had regular medical insurance, 27.4 million had major medical insurance, and 42.4 million had loss of income insurance.

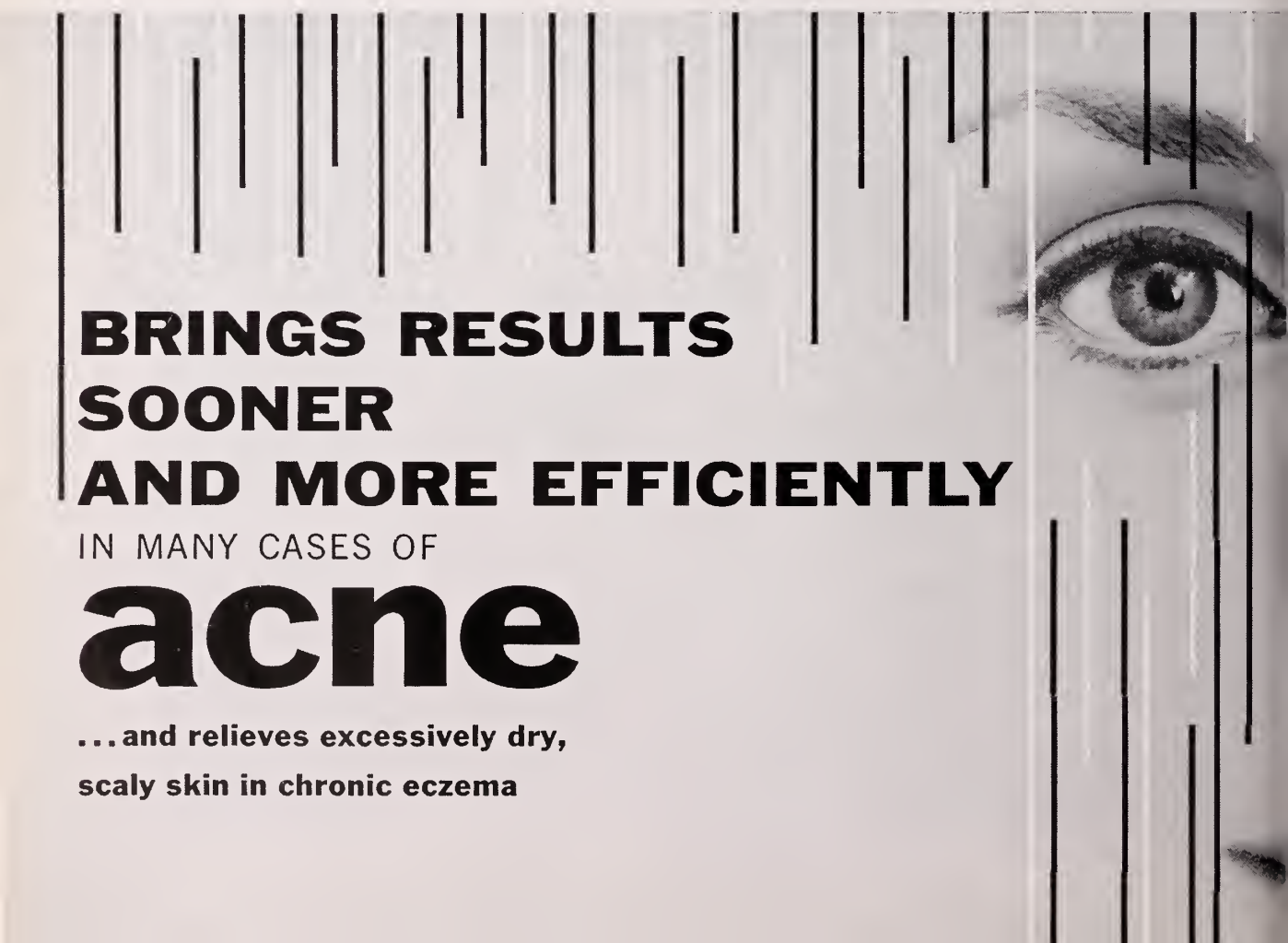
Pharmaceutical Company Launches New Sampling Plan

A radically new method of distributing prescription-drug samples to physicians has been put into effect for the first time by Winthrop Laboratories, with the introduction nationally of Winstrol, an important physiotonic agent.

As described by Charles B. McDermott, vice-president–sales and marketing, the new sampling method "is expected to be a distinct improvement in almost every respect over the traditional procedures because it provides absolute control over free medical samples of Rx products going to doctors."

Under the new plan, Winthrop's professional sales representatives are offering physicians an opportunity to study the effectiveness of Winstrol, an anabolic hormone, by writing a prescription order for 100 tablets for patients of their choice. Prescriptions are sent to Winthrop's main offices by the sales representatives.

Upon receipt of the prescription-request, a stock package of 100 tablets of Winstrol is sent to the



doctor. He also receives a standard medical report to be returned to Winthrop, in which he is asked to note clinical results obtained with the drug.

Massive Federal Support of Medical Research Questioned

The amount of money the government is giving to support the research programs of medical schools is affecting teaching and other functions of the schools adversely, John M. Russell said in the annual report of the John and Mary R. Markle Foundation issued recently.

"Because government grants have concentrated so heavily on the encouragement of research and because medical schools have the facilities and personnel to conduct research, most of the money in the bio-medical field has gone their way. However, medical schools have other and equally important jobs to do, such as training, education and service. Research is only one cylinder in the medical school motor. As a matter of fact, medical research itself won't get very far in the future if medical schools are not kept running on all of them. With grants for research projects, research facilities, research trainees, research equipment, research personnel and for anything in any way, shape or form, as long as they are for research, the 'central function' (which is education) and the 'proper internal balance' (among their major responsibilities) of medical schools have been seriously distorted. As matters stand, the medical school motor is not hitting on all cylinders and is in need of a tune-up. Uncle Sam's tinkering is not helping matters very much.

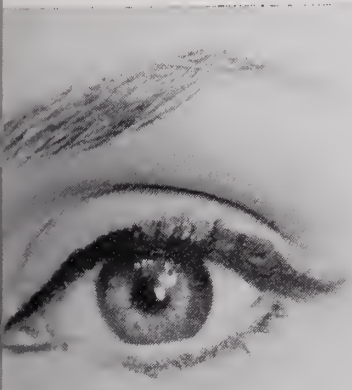
"The overemphasis on research and the consequent distortion of the medical school's function are natural results of the post-war preoccupation with attempts to solve various dreaded diseases by direct attack. This is the popular approach, which has been reflected in the Congress by larger and larger appropriations. Congressional committees have received reams of testimony urging such action — testimony given with the very best of intentions. The action taken by Congress has also been with the best of intentions, for in the area of health especially, they want to do the right thing."

Number of Hospital Beds Major Utilization Factor, Expert Claims

The number of hospital beds available is "the factor which, probably more than any other," determines the rate of hospital utilization in any community, state, or nation, a New York expert on hospital use said recently.

Milton I. Roemer, M.D., director of research at

continued on next page



quasol A

capsules

the original aqueous, natural vitamin A capsules

Samples and literature upon request.

u. s. vitamin & pharmaceutical corporation
Arlington-Funk Laboratories, division
New York 17, N. Y.

faster, more complete absorption because microscopic aqueous vitamin A particles pass through intestinal barrier more readily...

more effective because aqueous, natural vitamin A produces higher blood levels faster, and may diffuse more readily into affected tissues.

good tolerance because "burping" and allergenic factors have been removed.

for more dependable faster results Rx Aquasol A capsules . . . whenever vitamin A is indicated in

acne · dry skin · chronic eczemas · metaplasia of the mucous membranes · follicular hyperkeratosis · night blindness · lowered resistance to infections

three separate high potencies (water-solubilized natural vitamin A) per capsule:

25,000 U.S.P. units
50,000 U.S.P. units
100,000 U.S.P. units

Bottles of 100, 500 and 1000 capsules.

When vitamin A in high dosage is given for a prolonged period, it is advisable that treatment be inter-

the Sloan Institute of Hospital Administration, Cornell University, Ithaca, urged that serious research be undertaken to determine the "true need" for hospital beds at a given time and place according to some objective standards.

Writing in the November 1 issue of HOSPITALS, Journal of the American Hospital Association, Doctor Roemer predicted that such research might result "not in a reduction but in an elevation of the customary standard of 4.5 general beds per 1000 population. . . ."

"Whatever the level should be, it would permit the community, state or nation to finance hospital service at a level which it is prepared to finance — without anxieties and diatribes about overuse, mismanagement, and waste," Doctor Roemer said.

He reported a study of an upstate New York county where the hospital bed supply was suddenly increased by 42 per cent, which was followed by an immediate upswing in hospital admissions and length of stay.

While the higher use did not imply abuse, it did suggest the "central importance of the supply of beds in determining the hospital utilization rate . . . ," Dr. Roemer said. "It is quite reasonable to say that the earlier period was one of deprivation of hospital service. We simply do not know what an optimal level of hospital utilization was in the United States in 1959 or is in 1961."

Surgeons to Meet in Washington in April

The American College of Surgeons will hold its final 1962 sectional meeting in Washington, D. C., April 16 through 18. More than 1,500 doctors are expected to attend this meeting, open to all members of the medical profession. Headquarters hotel is the Sheraton-Park.

Doctor Robert J. Coffey, professor of surgery, Georgetown University, is chairman of the advisory committee on local arrangements. The committee has planned a program of interest to general surgeons and surgical specialists. Subjects will include: occlusive arterial disease, gastrointestinal bleeding, endocrine disorders, co-ordinated care in severe trauma, surgery of the biliary-pancreatic tract, and what's new in pediatric and in geriatric surgery.

Spend $110 Per for Health Needs

People in the United States spend an average of $110 a year for their health needs. In 1960, according to data just made available, the nation's total personal health bill amounted to $19.6 billion.

While virtually every person had some medical or dental expense in 1960, there was as usual great variability of health costs among families, said the Health Insurance Institute. A study several years ago showed one family in five spent under $50 annually for health care, one in six spent over $500, and one in 50 had medical expenses which exceeded $1,000 a year.

Hospital services accounted for the largest single part of 1960's personal health bill. One in every eight people — 22,970,000 in all — were admitted to the nation's 5,400 general hospitals. They paid $2 billion directly to the hospitals, while insurance benefits picked up $3.4 billion, of the total hospital charges of $5.4 billion.

More than three out of four hospital patients were insured for hospital costs.

14 Million Operations

Of all hospital patients, an estimated three-in-five are surgically treated. Surgical fees of an estimated 14 million hospital patients and physicians' fees for some 850 million visits in patients' homes, at doctors' offices and elsewhere, taken together, represented the next largest component of the 1960 health bill. Direct payments for physicians' and surgeons' services of all types totaled $3.5 billion. Insurance benefits paid another $1.6 billion.

Drugs and medicines cost Americans $3.9 billion in 1960. Appliances, such as eyeglasses, hearing aids and wheelchairs, cost $1.2 billion.

Fees for dentists' services reached $2 billion. Over $2 billion was expended for all other items, including services such as those provided by private nurses and other medical and dental professionals, for health insurance operating expenses, and for nursing homes.

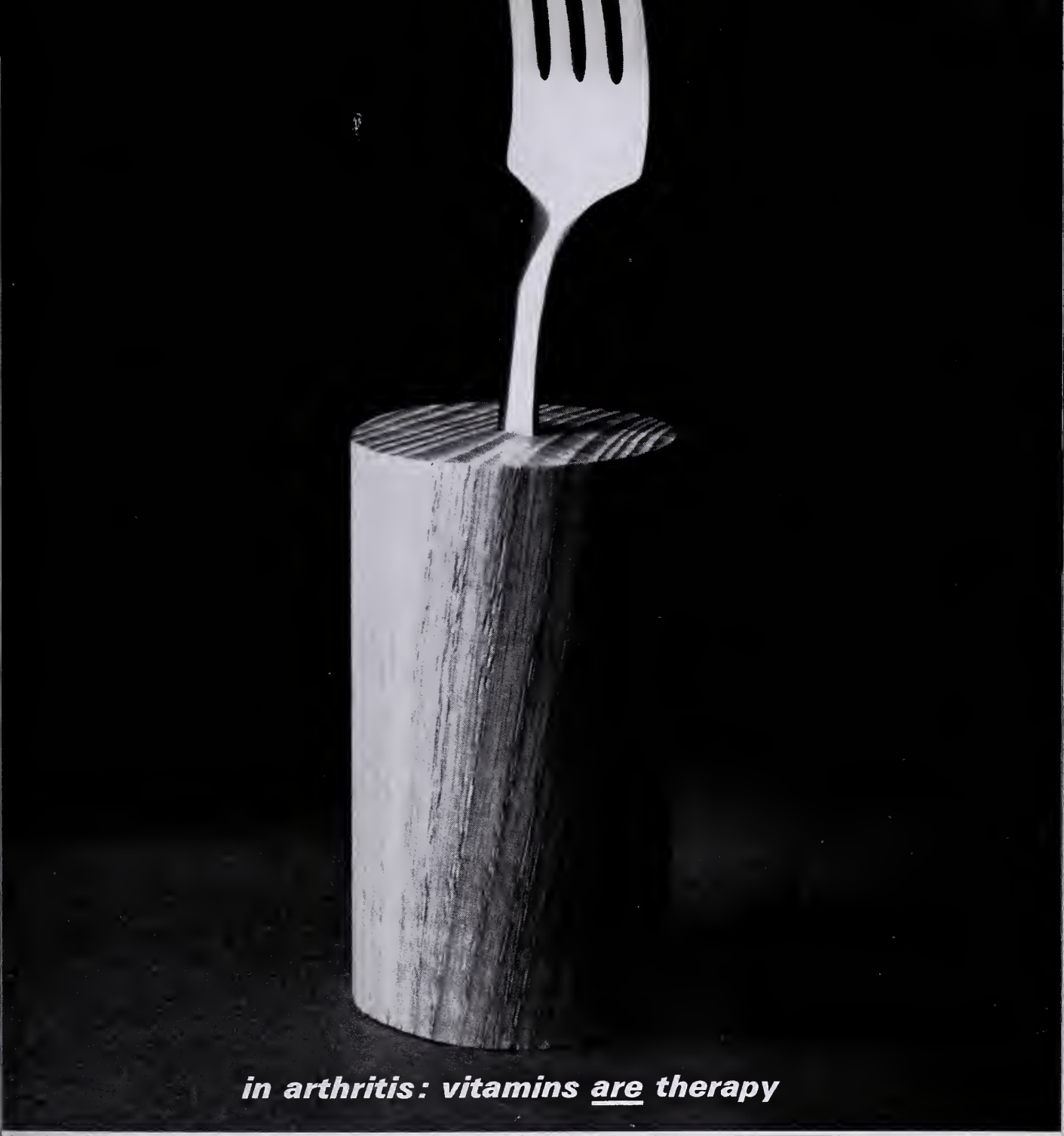
Curran & Burton, Inc.

INDUSTRIAL
AND WHOLESALE

COAL **OIL**

17 CUSTOM HOUSE STREET
PROVIDENCE, R. I.
DExter 1-3315

Patronize Journal Advertisers



in arthritis: vitamins <u>are</u> therapy

In dealing with the chronic stress of arthritis the physician often faces the problem of nutritional imbalance. High potency B and C supplementation is needed for rapid replenishment of tissue stores of these water-soluble vitamins. STRESSCAPS meet this need and help support the natural metabolic defenses in the disease. Supplied in decorative "reminder" jars of 30 and 100.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

STRESSCAPS®

Stress Formula Vitamins <u>Lederle</u>

Reading time: 1 minute

BRIEFS

FROM THE PHYSICIANS SERVICE PLAN OF THE RHODE ISLAND MEDICAL SOCIET

February, 1962

During 1961...

. . . 7,677 new members . . . 300,000 bills paid . . .

Membership

7,677 more Rhode Islanders joined Physicians Service during 1961 . . . to increase the state-wide enrollment to 585,580 members.

268 more companies selected Physicians Service, over other forms of health insurance, for their employees during the year. Over 2,800 firms now rely on Physicians Service to help pay doctor bills for employees.

13,686 persons upgraded from Plan A to the higher Plan B. Now, 148,051 members have the higher Plan.

Payments

300,000 members' medical and surgical bills were handled by Physicians Service during 1961. This is almost 15,000 more than the previous year.

$8,444,610 was paid in benefits for members during the year—an increase of almost $500,000 over 1960.

These significant gains—during a year in which we had no Direct Enrollment campaign—demonstrate the continuing public confidence in Physicians Service to provide the greatest return in benefits for the subscriber's dollar.

MARCH, 1962

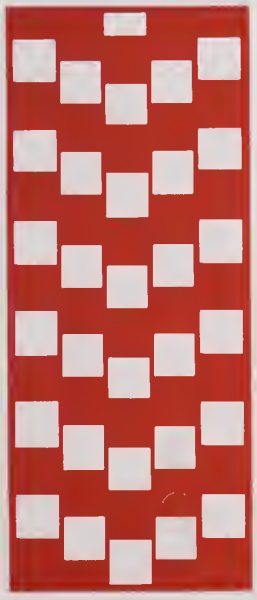
RHODE ISLAND

Medical Journal

Volume XLV, No. 3

Table of Contents, page 123

LIBRARY
NEW YORK ACADEMY
OF MEDICINE
1962



can parallel lines diverge?

Though the vertical lines *appear* to bow out at the bottom, the fact remains . . . they are parallel. Similarly, when facts regarding oral penicillins are rearranged, they may distort the true picture. Low price and high "blood levels" are important considerations, but it's what a drug *does* that counts.

V-Cillin K® achieves two to five times the serum levels of antibacterial activity (ABA) produced by oral penicillin G.[1] Moreover, it is highly stable in gastric acid and, therefore, more completely absorbed *even in the presence of food*. Your patient gets more dependable therapy for his money . . . and it's therapy he really needs.

For consistently dependable clinical results
prescribe V-Cillin K in scored tablets of 125 and 250 mg. or V-Cillin K, Pediatric, in 40 and 80-cc.-size packages. Each 5-cc. teaspoonful contains 125 mg. crystalline potassium penicillin V.

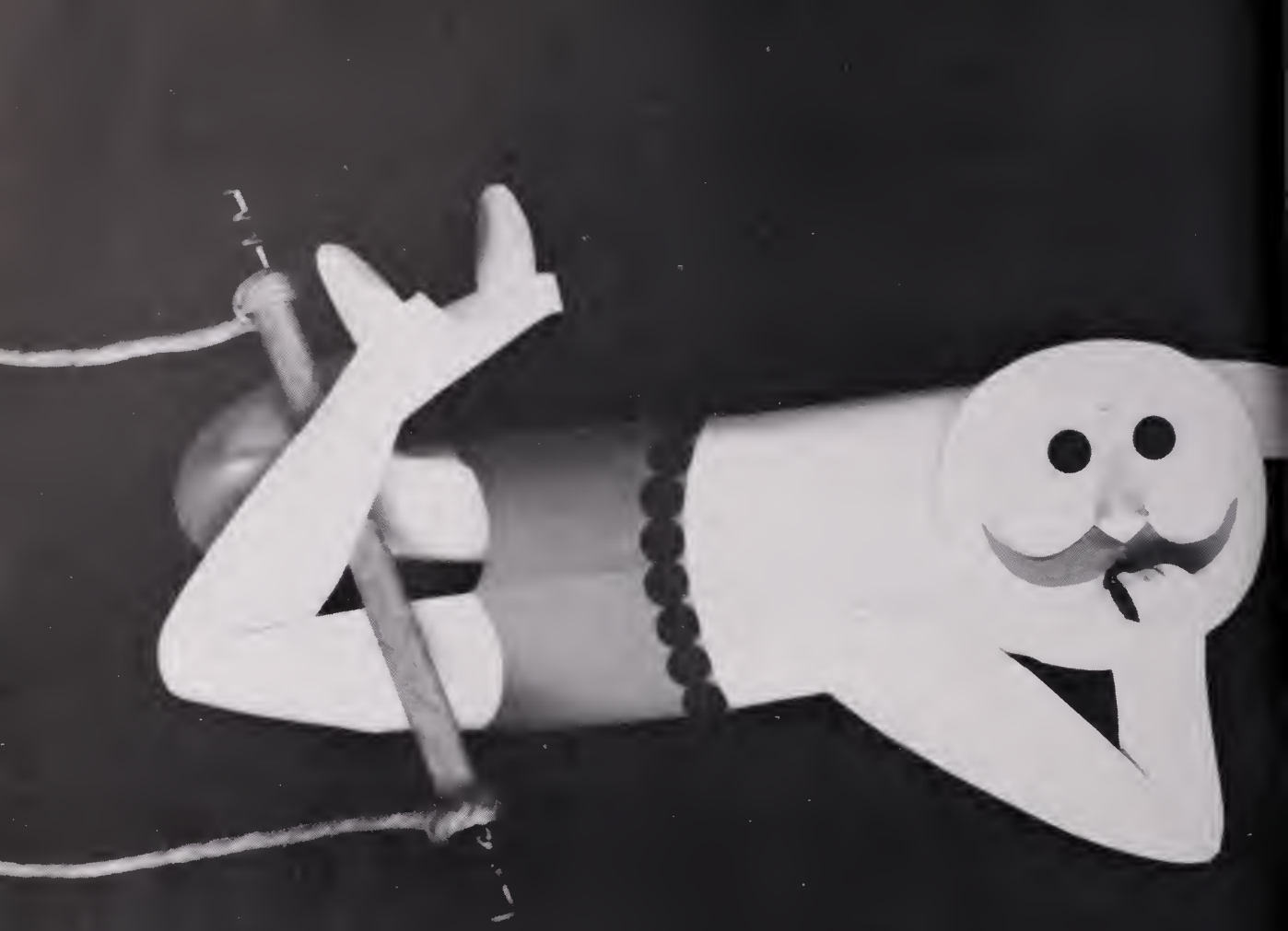
V-Cillin K® (penicillin V potassium, Lilly)

1. Griffith, R. S.: Antibiotic Med. & Clin. Therapy, 7:129, 1960.

This is a reminder advertisement. For adequate information for use, please consult manufacturer's literature. Eli Lilly and Company, Indianapolis 6, Indiana.

Lilly

233221



when the perfect combination
is threatened by a cough.



Benylin® Expectorant

ovides the right combination or effective cough control

our patient probably has a more "down-to-earth" occupation an the trapeze artist, but persistent coughing can cause a omparable drop in performance. Not so when you prescribe ENYLIN EXPECTORANT. This outstanding antitussive preparation ffectively suppresses coughs due to colds or allergy through s combination of judiciously selected ingredients.

enadryl,® a potent antihistaminic-antispasmodic, calms the ough reflex, relieves bronchial spasm, and reduces nasal stuffiness, sneezing, lacrimation, other symptoms associated with colds, and coughs of allergic origin. Efficient expectorants break down tenacious mucous secretions, thereby relieving respiratory congestion. And the pleasant-tasting, raspberry-flavored syrup provides a soothing demulcent action that eases irritated throat membranes.

BENYLIN EXPECTORANT contains in each fluidounce:

Benadryl® hydrochloride (diphenhydramine hydrochloride, Parke-Davis)	80 mg.
Ammonium chloride	12 gr.
Sodium citrate	5 gr.
Chloroform	2 gr.
Menthol	0.1 gr.
Alcohol	5%

Supplied: BENYLIN EXPECTORANT is available in 16-ounce and 1-gallon bottles.

This advertisement is not intended to provide complete information for use. Please refer to the package enclosure, medical brochure, or write for detailed information on indications, dosage, and precautions.

PARKE-DAVIS

84762 PARKE, DAVIS & COMPANY, Detroit 32, Michigan

Reading time: 1 minute

BRIEFS

FROM THE PHYSICIANS SERVICE PLAN OF THE RHODE ISLAND MEDICAL SOCIETY

"THE VERY SURVIVAL..."

"The very survival of the voluntary medical profession depends, in no small way, upon the success we can achieve in maintaining an effective balance between ethical ideals and economic needs. The embodiment of this principle lies in Physicians Service, which provides the means or expression of our sponsoring medical society's intelligent responsibility in this area of concern."

CHARLES J. ASHWORTH, M.D.
President at 13th Annual Meeting of
the Corporation of the R. I. Medical
Society Physicians Service.
January 29, 1962

Tell your patients they can now join Physicians Service and Blue Cross.

It's Open Enrollment Time

March 19th to 31st only!

No age limit! *Last chance to join for at least a year.*

31 CANAL STREET, PROVIDENCE 1, RHODE ISLAND

The RHODE ISLAND MEDICAL JOURNAL

Editorial and Business Office: 106 Francis Street, Providence, R. I.

Editor-in-Chief: SEEBERT J. GOLDOWSKY, M.D.

Managing Editor: JOHN E. FARRELL, SC.D.

Senior Editors

ALEX M. BURGESS, SR., M.D. HENRI E. GAUTHIER, M.D.

Advisory Board

(in addition to editors listed above)

JOHN A. DILLON, M.D. JOHN F. W. GILMAN, M.D. ROBERT V. LEWIS, M.D.
PETER L. MATHIEU, M.D. JOSÉ M. RAMOS, M.D. ROBERT W. RIEMER, M.D.
JACK SAVRAN, M.D. LESTER L. VARGAS, M.D.

Owned and Published Monthly by
THE RHODE ISLAND MEDICAL SOCIETY
Second-class postage paid at Providence, Rhode Island

Copyright, 1962, the Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island
Single copies, 25 cents . . . Subscription, $2.00 per year.

Volume XLV, No. 3 March, 1962

TABLE OF CONTENTS

PAGE

LUNG BIOPSY, J. JOHN YASHAR, M.D. 141

THIRTY-FIVE-YEAR REVIEW OF RHEUMATIC FEVER AND RHEUMATIC HEART DISEASE IN RHODE ISLAND (1925-1960), *Banice Feinberg,* M.D. 145

CONGENITAL ABSENCE OF THE GALL BLADDER, Report of a Case, *Anthony V. Migliaccio,* M.D., AND *Anthony J. Migliaccio,* M.D. 149

THE PHYSICIAN IN 1961, *Russell P. Hager,* M.D. 151

PHYSICIANS SERVICE IN 1961, *Charles J. Ashworth,* M.D. 153

A DOCTOR SPEAKS, Abstracts from a Report by *Meyer Saklad,* M.D. 155

EDITORIALS

Air Pollution — Public and Private 157

Nursing Homes: A Functional Re-evaluation 158

The Politics of Power in a Hospital 159

DEPARTMENTS

In the Editor's Mailbox 128

Book Reviews 134

Milk Commission Report — Providence Medical Association 139

House of Delegates, Rhode Island Medical Society 161

Rhode Island Medical Society Physicians Service, Report of Corporation Meeting 170

District Medical Society Meetings 174



AVAILABLE IN 2 POTENCIES:

MILPATH-400—Yellow, scored tablets of 400 mg. Miltown (meprobamate) and 25 mg. tridihexethyl chloride. Bottle of 50. *Dosage:* 1 tablet t.i.d. at mealtime and 2 at bedtime.

MILPATH-200—Yellow, coated tablets of 200 mg. Miltown (meprobamate) and 25 mg. tridihexethyl chloride. Bottle of 50. *Dosage:* 1 or 2 tablets t.i.d. at mealtime and 2 at bedtime.

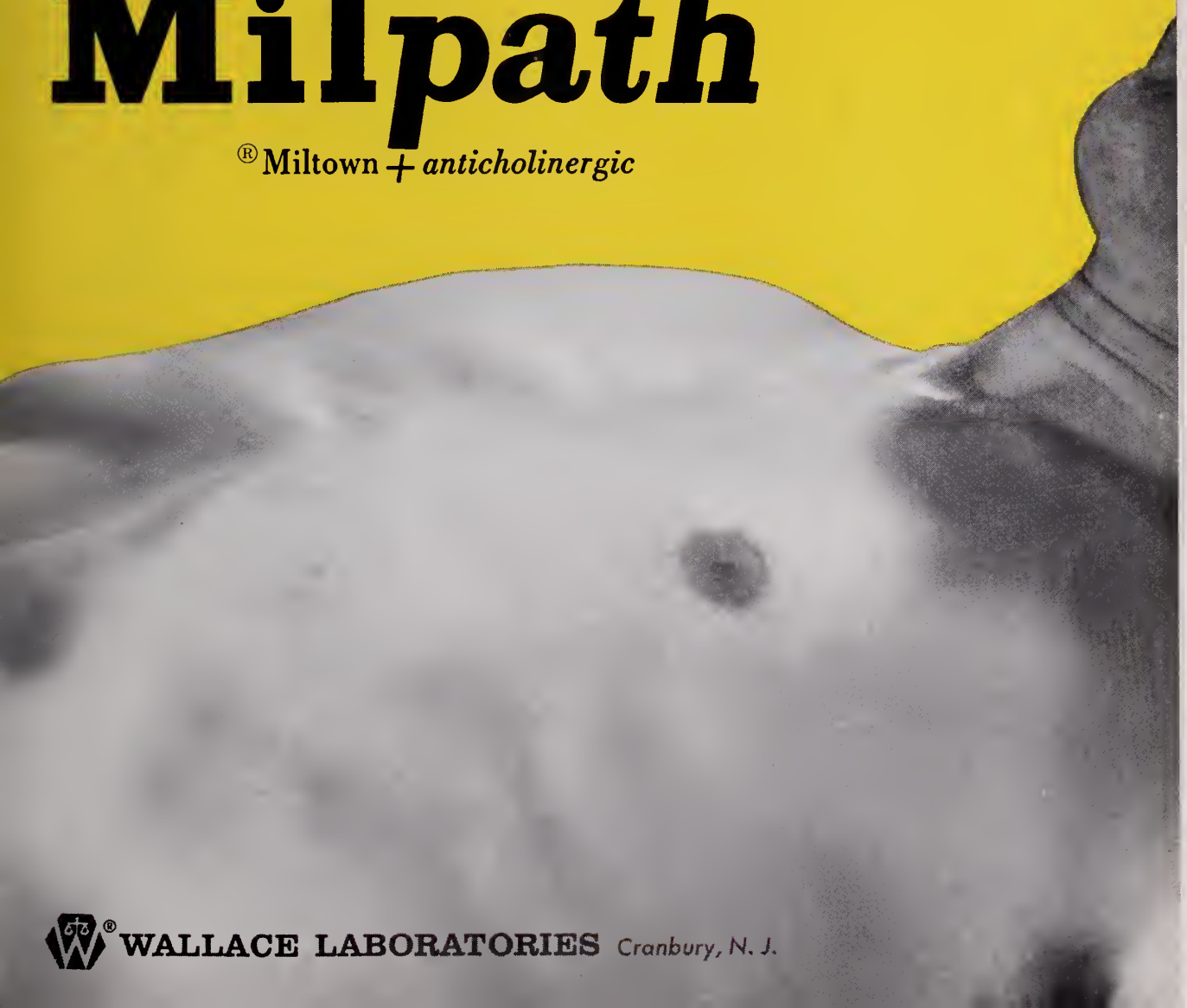
IN GASTROINTESTINAL DYSFUNCTION

Milpath helps you provide care of the man, rather than merely his stomach:

acts quickly to suppress hypermotility, hypersecretion, spasm and pain . . . alleviate anxiety and tension with minimal side effects.

Milpath®

®Miltown + *anticholinergic*



WALLACE LABORATORIES Cranbury, N. J.



Now Available for Rent . . . Pawtucket's Newest Professional Building

DARLINGTON PROFESSIONAL BUILDING

1499 NEWPORT AVENUE (NEAR MASSACHUSETTS STATE LINE)

Four Attractive Suites, each having 5 Spacious Rooms plus Lavette. Designed for the Medical Profession. Provisions for Medical and Dental Laboratories Available.

AMPLE OFFSTREET PARKING

For complete information write: Mr. Roger L. Messier, or call PA 5-0451

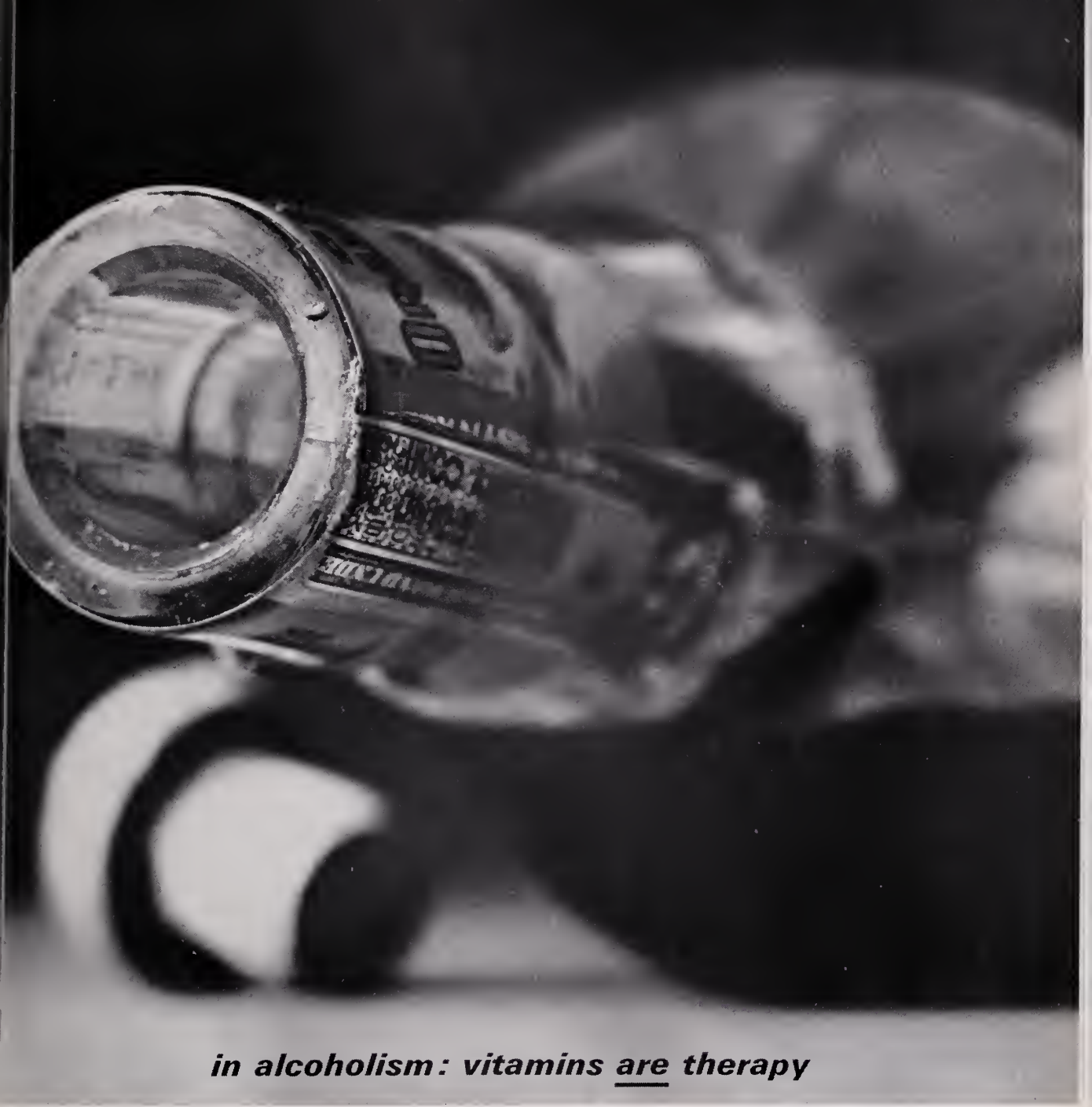


Wherever you go forget your telephone calls. We'll take them for you, day or night.

MEDICAL BUREAU

of the

Providence Medical Association



in alcoholism: vitamins are therapy

full "comeback" for the alcoholic is partly de-
endent on nutritional balance... aided by therapeutic
llowances of B and C vitamins. Typically, the alcoholic
atient is seriously undernourished...from long-standing
ietary inadequacy, from depletion of basic reserves of
vater-soluble vitamins. Supplied in decorative "reminder"
ars of 30 and 100.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

EDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

STRESSCAPS®

Stress Formula Vitamins Lederle

IN THE EDITOR'S MAILBOX

Current Literature on VD Available

To the Editor:

Since 1957, infectious syphilis has been increasing at an alarming rate in all races, sexes, ages, social groups, and geographic areas. Physicians who have not observed a single case of infectious syphilis in 20 years suddenly are finding it among their patients.

Concurrent with this resurgence, unfortunately, is a paucity of venereal disease literature and information available to the private physician.

To partially alleviate this situation and serve a pressing need, the Venereal Disease Program of the Public Health Service routinely abstracts current articles on venereal diseases from almost 1,000 journals both domestic and foreign. A publication titled CURRENT LITERATURE ON VENEREAL DISEASE including these abstracts is printed three or four times a year and indexed annually. It is distributed regularly free of charge to physicians on their personal request.

Will you please, as a service to your readers, alert them to the availability of this publication and suggest that if they wish to receive it, they may write to Communicable Disease Center, Atlanta 22, Georgia, Attention: Dr. William J. Brown, Chief, Venereal Disease Branch, requesting that their names be added to the mailing key for CURRENT LITERATURE ON VENEREAL DISEASE.

Sincerely yours,

WILLIAM J. BROWN, M.D.
Chief, Venereal Disease Branch
Communicable Disease Center, HEW
Atlanta, Georgia

January 24, 1962

Book Review Praised

To the Editor:

This is just a note to send you my cordial thanks for your review* of volume V in the Preventive Medicine Series of the history of the U.S. Army Medical Department in World War II, in the December 1961 issue of the RHODE ISLAND MEDICAL JOURNAL. I particularly appreciate your reviewing it from the standpoint of its purpose, which is to present the story of certain special communicable diseases during the war. You have no idea how many otherwise competent reviewers review our volumes from the standpoint of what they were never intended to be.

I shall call your review to the attention of the authors and editors of the volume, who, I know, will share my appreciation of your remarks.

The editor of this journal has been very kind in providing space for the review of our books, and I am grateful to him also.

Sincerely yours,

JOHN BOYD COATES, JR.
Colonel, Medical Corps
Editor-in-Chief

(The review mentioned was written by Doctor Raymond F. McAteer.)

Our Journal Widely Read

To the Editor:

The reprints arrived and look fine. Many thanks. In addition to the many requests from all over the U.S.A., we received the following number from other countries:

Canada	4
Czechoslovakia	2
England	1
Hungary	1
India	1
Italy	1
Norway	1
Scotland	1

Yours sincerely,

MARK D. ALTSCHULE, M.D.
McLean Hospital
Waverley, Mass.

E. P. ANTHONY, INC.
Druggists
WILBUR E. JOHNSTON, Phar. D.
RAYMOND E. JOHNSTON, B.S.
178 ANGELL STREET
PROVIDENCE, R. I.
GAspee 1-2512
Pharmacy License #225

THE HEART OF THE POPULOUS BLACKSTONE VALLEY



MENDON ROAD

CUMBERLAND • RHODE ISLAND

On Route #122 off the Eddie Dowling Highway
— 20 minutes to downtown Providence

IN these days of an increasingly mobile population, the trend in business is to decentralize . . . to leave the congestion of urban areas that are being choked by traffic . . . and to turn that same traffic to advantage in the wide open spaces of suburbia.

This advantage also accrues to physicians and other professional men who, in ever increasing numbers, are relocating in suburban professional buildings.

The new Cumberland Medical Center will afford this basic advantage, plus several not enjoyed in such profusion in other areas.

Bomb shelter included in the building.

Suites will be available with areas of from 460 to 790 square feet, and will be partitioned to suit the needs of each tenant.

The New

Cumberland Medical Center

For Full Information Phone

HOMESITE REALTY, Inc.

Agents

PAwtucket 6-5100

"The first prescription I ever wrote was for 'Empirin' with Codeine...



and it is still my stand-by for pain relief today."

PICTURE THE YOUNG DOCTOR with his first private patient, about thirty-five years ago. This is the moment, after years of study and guidance in classroom and at hospital bedside, when he assumes the full weight of responsibility for the well-being of his patient. He makes his diagnosis. The patient is in considerable pain, and his first concern is to relieve this discomfort. He writes a prescription for a new analgesic, a convenient drug combination that he believes will be of help. This patient (and many others to follow) finds gratifying relief, and the physician continues to rely upon this medication as the years go by.

Could this have been you in the 1920's? That was when 'Empirin' Compound with Codeine first came into general use (although plain 'Empirin' Compound has been well-known since the influenza epidemic of 1918). Satisfaction through the years has prompted doctors everywhere to depend on 'Empirin' with Codeine for relief of most all degrees of pain. For with this well-tolerated, reliable analgesic combination you can be sure of results, and feel secure in the fact that the liability of addiction is negligible.

Please accept our thanks for continuing to place your trust in a product that has been used more widely in medicine each year for the past four decades.

'EMPIRIN' COMPOUND with CODEINE PHOSPHATE*

Acetophenetidin, gr. 2½
Acetylsalicylic Acid, gr. 3½
Caffeine, gr. ½

Remember there are now four strengths available...

*Warning—May be habit-forming.
Subject to Federal Narcotic Regulations.

No. 1 — gr. ⅛
No. 2 — gr. ¼
No. 3 — gr. ½
No. 4 — gr. 1

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.



"cramps" don't cramp her style...

when you prescribe

Trancoprin®

Aspirin.....(5 grains) 300 mg.
Trancopal® (brand of chlormezanone).....50 mg.

Trancoprin is more than a simple analgesic: It deals with cramping pains in three ways. Besides dimming pain perception, Trancoprin, through its tranquilizing action, reduces anxiety and raises the tolerance for discomfort. And, against the spasm caused by pain which, in turn, produces more pain. Trancoprin exerts its skeletal muscle relaxant action.

Trancoprin is exceptionally safe to use: Fewer than two and a half per cent of patients can be expected to have any side effects, and these are of a minor nature.

Available in bottles of 100 tablets. The usual dosage in dysmenorrhea is 2 tablets 3 or 4 times daily.

Winthrop LABORATORIES, New York 18, N.Y.

Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications. 1602M

INDICATION: *Surgical procedure*



INDICATED: Chymoral®

cuts healing time in surgical procedures

The inflammation, swelling and pain that follow surgical trauma resolve more quickly when Chymoral therapy is employed pre- and post-operatively than when healing is allowed to take its natural course. Chymoral modifies inflammatory reaction, dissipates edema and blood extravasates in the tissues, improves regional circulation, and thereby assists the reparative functions of the body. Chymoral also hastens resolution of inflammation, hematoma and edema in accidental trauma—fractures, sprains, contusions and lacerations.[1-4]

Controls inflammation, curtails swelling, curbs pain

1. Teitel, L. H., *et al.*: Indust. Med. 29:150, 1960. 2. Billow, B. W., *et al.*: Southwestern Med. 41:286, 1960. 3. Beck, C., *et al.*: Clin. Med. 7:519, 1960. 4. Clinical Reports to the Medical Department, Armour Pharmaceutical Company, 1960.

ARMOUR PHARMACEUTICAL COMPANY
KANKAKEE, ILLINOIS • *Originators of Listica®*

CHYMORAL

Chymoral is an ORAL anti-inflammatory enzyme tablet specifically formulated for intestinal absorption. Each tablet provides enzymatic activity, equivalent to 50,000 Armour Units, supplied by a purified concentrate which has specific trypsin and chymotrypsin activity in a ratio of approximately six to one. ACTION: Reduces inflammation of all types; reduces and prevents edema except that of cardiac or renal origin; hastens absorption of blood and lymph extravasates; helps to liquely thick tenacious mucous secretions; improves regional circulation; promotes healing; reduces pain. INDICATIONS: Chymoral is indicated in respiratory conditions such as asthma, bronchitis, rhinitis, sinusitis; in accidental trauma to speed absorption of hematoma, bruises, and contusions; in inflammatory dermatoses to ameliorate acute inflammation in conjunction with standard therapies; in gynecologic conditions such as pelvic inflammatory disease and mastitis; in obstetrics as episiotomies and breast engorgement; in surgical procedures as biopsies, hernia repairs, hemorrhoidectomies, mammectomies, phlebitis and thrombophlebitis; in genitourinary disorders as epididymitis, orchitis and prostatitis; in dental and oral surgery as fractures of the mandible or maxilla, difficult or multiple extractions, and alveolectomies. CONTRAINDICATIONS: None known. INCOMPATIBILITIES: None known. Antibiotics as well as generally accepted measures may be coadministered. SIDE EFFECTS: Mild gastric upsets, rarely encountered. DOSAGE: Recommended initial dose is two tablets q.i.d.; one tablet q.i.d. for maintenance. SUPPLIED: Bottles of 48 and 250 tablets.

CHYMORAL *ORAL systemic anti-inflammatory enzyme tablet*

BOOK REVIEWS

WOUND HEALING. Proceedings of a Symposium Held on 12-13 November, 1959 at the Royal College of Surgeons of England. Edited by D. Slome, M.A., PH.D., M.B., CH.B. Organised by Smith & Nephew Research Ltd. Pergamon Press, N.Y., Lond., 1961. $5.00

"Much remains obscure; even some of the most fundamental aspects of this biological phenomenon are still unsettled." This observation was made by the chairman, D. Slome, in his introductory remarks at a symposium on wound healing held in the Royal College of Surgeons in November 1959. It was hoped that by bringing together workers in various disciplines having a common interest in the subject new ideas would emerge from the discussions which would in turn lead to gaining more knowledge of wound healing.

Thus, a program was presented to an audience of basic research investigators and of practicing surgeons. This volume contains the nine papers comprising that program together with an admirable introduction by the chairman in which he previews and summarizes the papers which follow. Unfortunately, the value of the book is diminished because it does not contain any of the discussions which followed the presentation of each paper.

Seven of the papers describe some techniques and results of biologic experiments in wound healing and two relate some of the clinical problems encountered in wound healing. The specific subjects of the various authors are: a new theory on the control of mitotic activity in the skin, especially following wounds; the site of, and the mechanism of wound contraction; the role of collagen in wound healing; some of the factors which influence skin metabolism, and their relation to wound healing; the effect of radiation on wound healing; the effects on healing wounds of various types of dressings; the tensile strength of healing wounds in aponeurosis; the search for an ideal dressing or method of treating burns; and, difficulties in closing large open wounds by grafting. References for each paper are listed and there is a detailed index.

The book is not presented as a text on the treatment of wounds or a complete evaluation of all knowledge of wound healing. For the basic science researcher and the interested clinician, however, it does present information on some focal points of interest in the current investigation of this fundamental biological process.

HAROLD L. BEDDOE, M.D.

THE ART OF THINKING by Dagobert D. Runes. Philosophical Library, Inc., N.Y., 1951. $2.75

This is a small, ninety-page volume. After carefully reading this book, I felt that it does stimulate one's thinking. However, I found myself in disagreement with many parts of it. There were many repetitions, especially when the author is ventilating his personal feelings regarding attitudes toward world problems, and in particular when he is interpreting the motivations and rationalizations of planned and constructive suggestion as to one's certain national leaders who represented an aggressive segment of nationalistic groups. I felt that his thinking was in retrospect, rather than offering a thinking processes.

I found myself in harmony with him, however, on many of his viewpoints, and this made this volume stimulating and worth reading. I felt, however, that more emphasis should be placed on positive rather than negative attitudes. This would have seemed to me more appropriate. His emphasis on Christian attitudes and principles is refreshing.

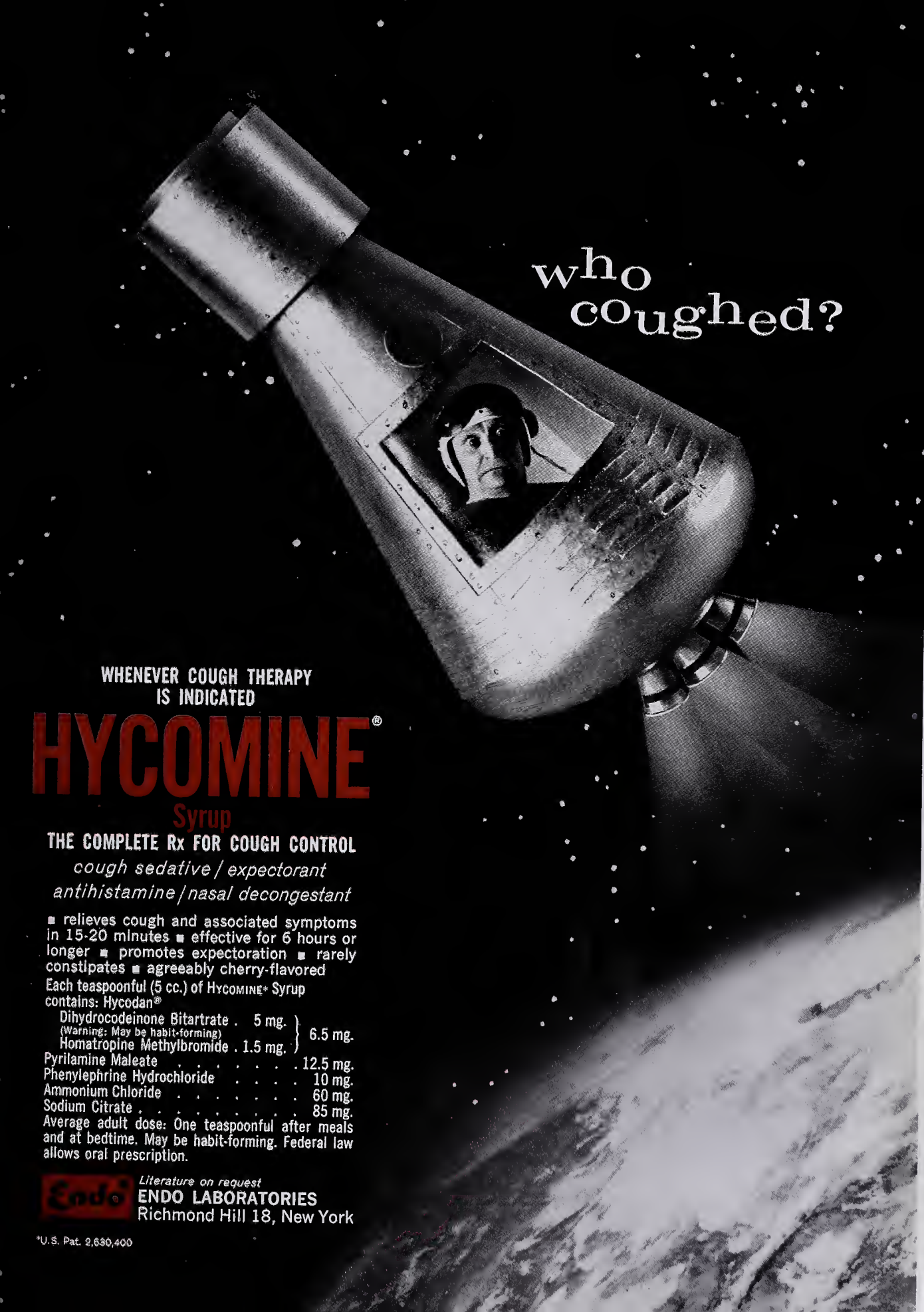
The author has a vast knowledge of social problems and moral issues both in the present and in the past. On a subject as difficult and as varied as THE ART OF THINKING it would seem to me that he has accomplished a fairly good job and has made his subject in this small volume at least interesting to read and contemplate.

LAURENCE A. SENSEMAN, M.D.

DISTURBANCES OF HEART RATE, RHYTHM AND CONDUCTION by Eliot Corday, M.D., and David W. Irving, M.D. W. B. Saunders Co., Phil., 1961. $8.50

The recognition of disturbances in heart rate, rhythm and conduction is a difficult and confusing process to many medical practitioners. Since many of these conditions are most often seen in the home or in the office by the general practitioner, their recognition and early treatment is of the utmost importance. With that thought, the authors have

concluded on page 136



WHENEVER COUGH THERAPY IS INDICATED

HYCOMINE®

Syrup

THE COMPLETE Rx FOR COUGH CONTROL

cough sedative / expectorant
antihistamine / nasal decongestant

■ relieves cough and associated symptoms in 15-20 minutes ■ effective for 6 hours or longer ■ promotes expectoration ■ rarely constipates ■ agreeably cherry-flavored

Each teaspoonful (5 cc.) of HYCOMINE* Syrup contains: Hycodan®

Dihydrocodeinone Bitartrate (Warning: May be habit-forming)	5 mg.	6.5 mg.
Homatropine Methylbromide	1.5 mg.	
Pyrilamine Maleate		12.5 mg.
Phenylephrine Hydrochloride		10 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

Average adult dose: One teaspoonful after meals and at bedtime. May be habit-forming. Federal law allows oral prescription.

Literature on request
ENDO LABORATORIES
Richmond Hill 18, New York

*U.S. Pat. 2,630,400

TESTIMANIMAL



Perfect drink for growing families!

WARWICK CLUB
GINGER ALE
It sings in the glass



PATRONIZE JOURNAL ADVERTISERS

BOOK REVIEWS

concluded from page 134

written this text, which is useful for the student, the resident, the general practitioner and the cardiologist.

The book is divided into twenty-one chapters. The first two deal with normal anatomy, physiology, and a summation of the disturbances. The next ten chapters deal with the separate disturbances from those of the sino-auricular node through cardiac arrest.

There is an excellent chapter on hemodynamics and also on bedside diagnosis without the aid of the electrocardiogram. The chapters sixteen through twenty deal with the arrhythmias associated with myocardial infarction, surgery and anesthesia, electrolyte disturbances, enzyme elevations, and emotional factors. The last chapter is a most comprehensive listing of all drugs useful in the treatment of arrhythmias with mode of action, toxicity, and dosage procedures.

The entire book is extremely interesting and readable. Each condition is completely covered from etiology through the accepted treatment. The illustrations of each arrhythmia with electrocardiogram tracings are worth the price of the book itself.

There are last, but far from least, 467 references covering 21 pages, in the back of the book; which represents a great deal of work and study.

This reviewer highly recommends this book as the most complete text on the subject available today.

DONALD L. DE NYSE, M.D.

The Doctor's Dilemma Is Solved

No matter how carefully a country's laws are framed, occasionally the strict construction of one of them is bound to result in nonsense. When this occurs, it is essential for the health of the country's whole legal system that administrative procedures be available to make sense out of the situation.

An instance in point arose over the status here of a Scarsdale resident, Dr. Cassim Jadwat, whose deportation to his native South Africa was eight times ordered by the U. S. Immigration Service. Dr. Jadwat has finally received permission to stay in this country, either by applying for permanent residence while here, or by following regular immigration routine from abroad.

The deportation of Dr. Jadwat, a much needed anesthesiologist at Grasslands Hospital, would have been nonsense from two angles. Had he been sent back to South Africa, the country's apartheid restrictions would have prevented him from practicing his specialty. And meanwhile, Grasslands would have lost a specialist almost impossible to replace, and might have forfeited recognition as an accredited teaching hospital for anesthesiology.

There is sound reason behind the regulations which prompted the deportation proceedings. It is obviously not in the interests of foreign countries to send citizens abroad for training, only to lose them to an adoptive country which offers higher living standards or other advantages. It is entirely legitimate for this country to require that a professional man admitted expressly for training return to his own country when that training is accomplished. The procedure becomes gibberish, however, when the student's own country doesn't really want him back.

The Attorney General's office and the Immigration Service have now arrived at a solution for the problem, and Dr. Jadwat and Grasslands can both rest easy after two years of uncertainty. The revocation of the deportation order is a commendable achievement in making sense out of nonsense. It's only regrettable that it took so long.

Reprinted from the Scarsdale (N.Y.) *Inquirer*

AN AMES CLINIQUICK®
CLINICAL BRIEFS FOR MODERN PRACTICE

WHY TEST URINE ROUTINELY FOR PROTEIN ?

In a recent series of 278 diabetic patients, 34.2 per cent (95) had proteinuria. Of this group, almost 3 out of 5 had previously unrecognized renal disease, usually asymptomatic and untreated.[1] Proteinuria may give valuable warning not only of infectious and other renal disorders, but also of degenerative diabetic nephropathy.[2]

With URISTIX Reagent Strips, testing for proteinuria *and* glucosuria may be conveniently done at the same time. URISTIX is "... reliable for routine clinical use."[1] It will not give false-positive protein reactions with oral hypoglycemic agent metabolites. URISTIX is simple for patients to use at home and is timesaving for technicians.[1]

References: (1) Moss, J. M.; Schreiner, G. E., and Sweeney, V.: M. Times *89*:12 (Jan.) 1961. (2) El Mahallawy, M., and Sabour, M. S.: J.A.M.A. *173*:1783 (Aug. 20) 1960.

for broader day-to-day protection of the diabetic patient

DIP AND READ

uristix®

urine protein · glucose

AMES COMPANY, INC Elkhart • Indiana Toronto • Canada

1 dip . . . 10 seconds . . . 2 readings

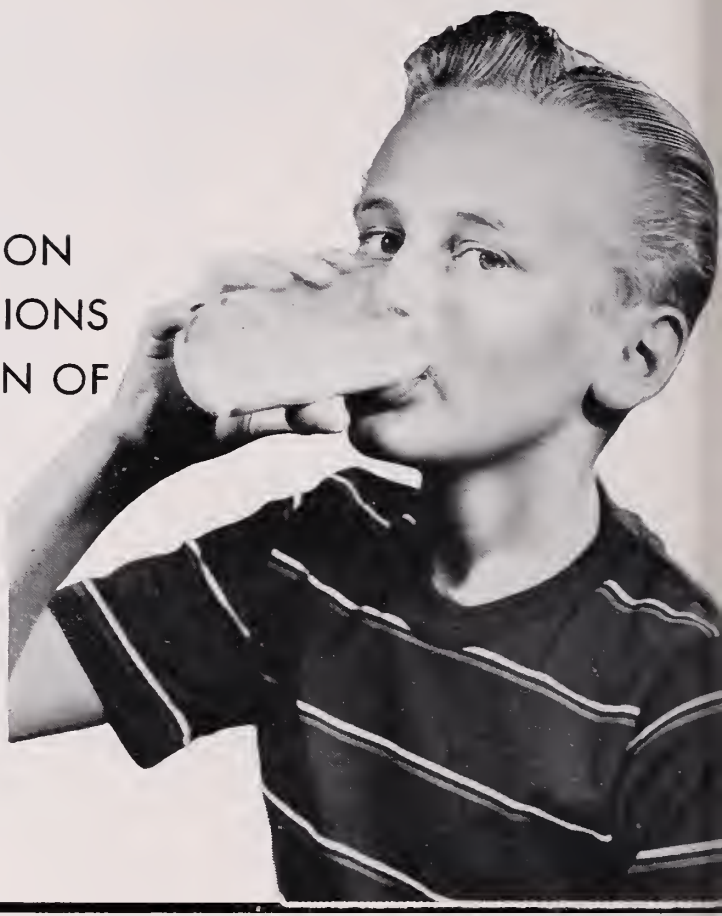
available: URISTIX Reagent Strips, bottles of 125

20062

Certified MILK

THE AMERICAN ASSOCIATION OF MEDICAL MILK COMMISSIONS SUPERVISES THE PRODUCTION OF

Certified MILK



1. CLEANER. Lowest bacteria-count. Milk checked before each milking. All utensils, bottles, and equipment sterilized before use.

2. BETTER-PROTECTED. Strictest medical supervision of herds and employees. Frequent examinations and laboratory-control AT THE FARM are required.

3. AUTOMATIC MILKING. Cows are milked automatically by electric machine. Milk is bottled without exposure to air or human touch.

4. BOTTLE CLOSURES. Must be of the highest quality to provide complete protection for the milk and bear approval of The American Association of Medical Milk Commissions.

5. MORE NUTRITIOUS. Cows scientifically fed balanced ration. Nutrition control from soil to delivery of milk. Same diet all year.

6. LONGER-LASTING, BETTER-TASTING. Diet control, special handling, and shortest time of delivery from cow to consumer assure fine fresh flavor that lasts for weeks.

7. THE DOCTOR'S MILK. Produced, processed, bottled on farms supervised by Medical Milk Commissions. Each bottle bears the seal of the A.A.M.M.C. and names of the supervising Commission and producing farm.

MILK COMMISSION OF PROVIDENCE MEDICAL ASSOCIATION

HILLSIDE FARMS, INC., 1308 Phenix Ave., Cranston, WI 2-3400
Produced at Hillside Farm, Cranston, R. I.

H. P. HOOD & SONS, 135 Harris Ave., Providence, DE 1-3024
Produced at Hood Certified Farm, Beverly, Mass.

WHITING MILK CO., 40 Tockwotton St., Providence, GA 1-5363
Produced at Hampshire Hills Farm, Wilton, N. H.

MILK COMMISSION REPORT — PROVIDENCE MEDICAL ASSOCIATION, 1961

Certified milk in Providence during 1961 was obtained from the following farms: Cherry Hill Farm, North Beverly, Mass.; Hampshire Hills Farm, Wilton, N. H.; Hillside Farm, Cranston, R. I.

Through the courtesy and co-operation of the Boston Commission we have accepted their certification of one farm from Massachusetts and one from New Hampshire.

All of the herds are under State and Federal supervision and are free from Tuberculosis and Brucella abortus infections.

Vitamin D Certified Milk is defined as whole Certified Milk rendered antirachitic by irradiation or by the addition of a concentrate and shall be of sufficient vitamin potency to show, by biological assay, a content of at least 400 U.S.P. units per quart.

The Wisconsin Alumni Research Foundation of Madison, Wisconsin, has been doing the assaying of Vitamin D from Hillside Farm. During the year 1961, two samples of Hillside Farm's milk were tested by the Wisconsin laboratory and found to be satisfactory. These tests were done in May and October.

Certified Fat-free (Skim) Milk, containing not more than 0.05 per cent butter fat, and with Vitamin A added has conformed to the standards set by the American Association of Medical Milk Commissions.

During the past year the analysis of milk samples has been performed in the laboratory of the Milk Department of Providence, which is located at the Charles V. Chapin Hospital. Doctor Joseph Smith, the Milk Inspector, and his assistant, Mr. Richard S. McKenzie, have been most co-operative in doing this work for the Milk Commission.

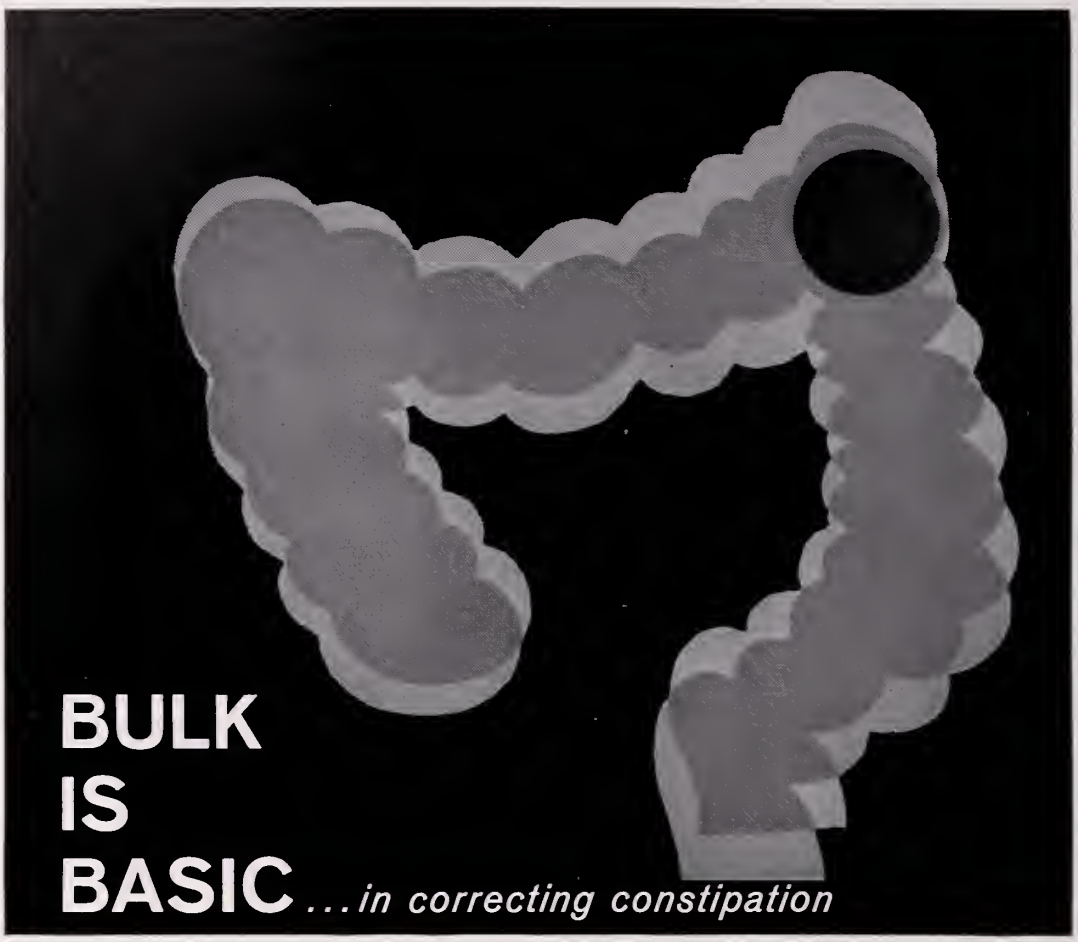
During the past year the Commission has inserted a full-page advertisement in the Rhode Island Medical Journal about the good qualities of Certified Milk and also lists the dealers who sell this excellent milk.

The Sanitary Inspector is appointed by the Commission to supervise the sanitary conditions at the farm and the physician is responsible for the health of the employees at the farm. Both of the men are licensed practitioners. The Veterinarian to the farm is also appointed by the Commission.

John T. Barrett, M.D., *Chairman*
Reuben C. Bates, M.D., *Secretary*
Bertram H. Buxton, Jr., M.D.
Harold G. Calder, M.D.
John E. Farley, M.D.
John P. Grady, M.D.
Maurice Kay, M.D.
Henry E. Utter, M.D.

MONTHLY AVERAGES OF CERTIFIED MILK FOR 1961

	CHERRY HILL H. P. HOOD			HAMPSHIRE HILLS						HILLSIDE FARM					
	Pasteurized			Pasteurized			Skimmed with Vit. A & D			Pasteurized			Skimmed with Vit. A & D		
	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.
January	4.0	12.85	33	4.6	14.08	45	.03	8.93	180	4.3	13.13	31	.02	8.91	20
February	4.1	13.04	13	4.4	13.90	313	.09	9.01	50	4.1	13.14	38	.03	9.06	40
March	4.0	13.02	5	4.5	13.85	40	.03	8.93	128	4.0	12.94	44	.02	8.64	34
April	4.1	12.81	58	4.4	13.67	40	.18	9.00	22	3.9	12.11	51	.03	8.87	30
May	4.1	12.83	20	4.2	13.37	116	.03	8.94	150	3.9	12.61	40	.01	8.86	65
June	4.0	12.76	26	4.5	13.58	103	.03	8.89	73	4.0	12.64	60	.01	8.77	55
July				4.6	13.64	360			380	3.8	12.45	73	.01	8.82	136
August				4.6	13.70	232	.05	8.94	345	4.0	12.58	113	.02	8.76	143
September				4.3	13.48	170	.03	8.89	120	4.5	13.29	230	.03	8.77	217
October	4.2	12.98	113	4.6	13.76	495				4.4	13.34	128	.03	8.79	377
November	4.0	12.79	80	4.8	14.02	280	.04	9.09	185	4.3	13.44	136	.03	8.96	196
December	4.2	13.18	40	4.8	14.02	56	.09	9.03	150	4.2	13.29	213	.03	8.93	176
Yearly Average	4.07	12.92	43	4.5	13.75	187	.06	8.96	162	4.1	12.91	96	.02	8.84	124



METAMUCIL®

BRAND OF PSYLLIUM HYDROPHILIC MUCILLOID

STRENGTHENS THE COLONIC REFLEX

"The natural stimulus to peristalsis[1]... is the distension of the intestinal wall...."

The effectiveness of Metamucil in correcting constipation is a direct result of its physiologic action.

The stimulus which initiates the defecatory reflex is the fecal mass in the lower sigmoid colon and rectum. Metamucil provides that mass as a bland, nonirritating, easily compressed bulk, similar in consistency to the normal protective mucus of the colon. Taken regularly, Metamucil tends to correct the insensitive reflex of a bowel abused by laxatives and to restore the natural responsiveness to the urge to stool.

Metamucil is available as Metamucil powder in 4, 8 and 16-oz. containers and as lemon-flavored Instant Mix Metamucil in cartons of 16 and 30 single-dose packets.

1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice. ed. 6, Baltimore, The Williams & Wilkins Company, 1955, p. 578.

G. D. SEARLE & CO.

CHICAGO 80, ILLINOIS

Research in the Service of Medicine

The RHODE ISLAND MEDICAL JOURNAL

VOL. XLV MARCH, 1962 NO. 3

LUNG BIOPSY*

J. JOHN YASHAR, M.D.

The Author. *J. John Yashar, M.D., Assistant Surgeon, Active Staff, Miriam Hospital; Thoracic and Cardiovascular Surgeon, Active Staff, Roger Williams General, Pawtucket Memorial, and St. Joseph's hospitals.*

SINCE THE ORIGINAL REPORT by Klassen and associates[1] on limited thoracotomy and lung biopsy in the diagnosis of diffuse pulmonary disease, there have been only scattered reports in the literature.[2,3,4,5] Exploratory thoracotomy and lung biopsy have long been accepted procedures for isolated pulmonary nodules when there is suspicion of neoplastic disease. However, lung biopsy for the diagnosis of diffuse pulmonary disease has not gained ready acceptance. Disseminated pulmonary diseases regardless of etiology may have similar radiological findings (Table 1). While in some asymptomatic patients the disease is discovered only during routine survey studies, others may have respiratory or generalized symptoms. Definite diagnosis can often be made by history, including geographic and industrial exposure, physical examination, skin tests, complement fixation studies, gastrointestinal series, sputum examination, bronchoscopy, and scalene node biopsy. Patients for whom a definite diagnosis cannot be established are often subjected to periodical chest X-ray studies, repeated office visits, and hospital admissions. Adequate treatment of patients requires an adequate diagnosis. The patient often shares the physician's uncertainty. In such patients the diagnosis can be established by lung biopsy. Needle biopsy, however, besides being unsatisfactory for tissue diagnosis carries the risk of hemothorax, pneumothorax, and contamination of the pleural space. Its use should be reserved for patients with inoperable peripheral pulmonary malignancy in whom tissue diagnosis is desired prior to radiation therapy.

*Presented at the annual John F. Kenney Clinic Day, at the Memorial Hospital, Pawtucket, Rhode Island, October 25, 1961.

Technique

Under endotracheal anesthesia an eight to ten centimeter incision is made at a suitable place based on chest X-ray studies (Figure 1). The chest wall muscles are incised in the line of the skin incision, and the periosteum is incised and reflected. The rib is elevated, and the pleura beneath it is exposed. After limited exploration of the lung, a suitable place usually at the margin of one of the lobes is chosen and a small wedge-shaped section is excised using non-crushing clamps. The cut edge of the resected lung is closed with continuous chromic catgut sutures. A chest catheter is placed in the pleural space through a stab wound and is connected to water seal drainage. The chest wall is then closed in layers. The thoracotomy tube is usually left in the pleural cavity for a period of 24 to 48 hours until there is complete expansion of the lung and air bubbles or bleeding have ceased. The patient is usually out of bed the day after surgery, and discharged from the hospital in five to seven days.

Case Histories

Case 1, M. V. — Miriam Hospital No. 77061. This thirty-two-year-old white female was admitted

TABLE 1
Etiology of Diffuse Pulmonary Lesions

1. Inhaled substances (pneumoconioses)
2. Infections:
   Bacteria
   Rickettsia
   Fungi
   Protozoa and viruses
3. Idiopathic disease:
   Idiopathic fibrosis
   Hamman-Rich syndrome
   Eosinophilic granuloma
   Polycystic disease
4. Systemic disease:
   Sarcoidosis
   Lupus erythematosus
   Scleroderma
   Polyarteritis
5. Neoplasm:
   Primary
   Metastatic
6. Cardiovascular lesions

continued on next page

on February 21, 1959, with a two and a half month history of progressive nonproductive cough and easy fatigability. She apparently had been in good health all her life. Complete physical examination on admission was essentially negative. The chest was symmetrical, and lungs were clear to percussion and auscultation. Chest X-ray revealed the presence of fine and diffuse infiltration of both lungs (Figure 2). The heart and mediastinal structures were within normal limits. Laboratory studies were as follows: Hemoglobin 12.5 gm., white blood count 6950, with a normal differential. Total protein 6 gm., albumin 3.4 gm., globulin 2.6, alkaline phosphatase 3.2 units. Sputum cultures for acid fast organisms and fungus were negative. Routine culture grew streptococcus viridans after five days. Skin tests for fungi and acid fast organisms were negative. Scalene node biopsy revealed only chronic lymphadenitis.

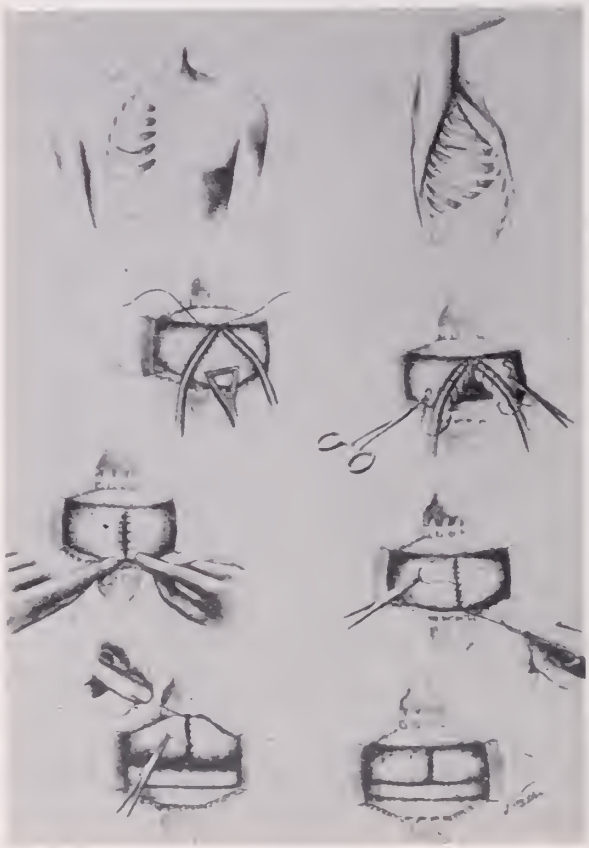


FIGURE 1

Steps in pulmonary biopsy (after Andrews, reproduced with permission of the author).

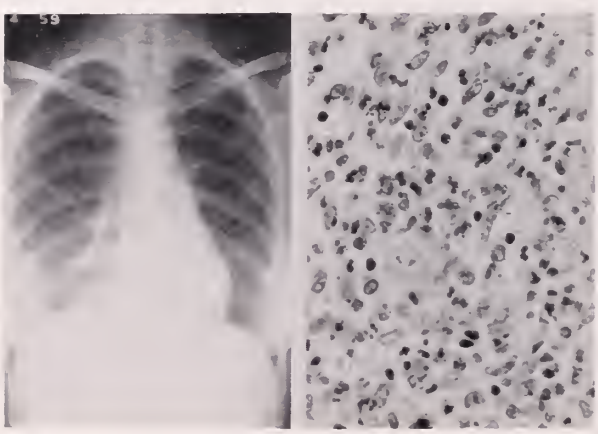


FIGURE 2

(Case 1) Chest X-ray showing diffuse infiltration of both lower lobes. Photomicrograph in the same case showing eosinophilic granuloma.

After a month of observation radiological findings were essentially the same. Therefore, on March 4, 1959, under endotracheal anesthesia biopsy from the right middle and upper lobes was performed. This revealed eosinophilic granuloma (Figure 2). Patient's postoperative course was smooth, and she was discharged from the hospital on her seventh postoperative day.

Case 2. M. D. — Miriam Hospital No. 86376. This sixty-four-year-old white female had had more than ten admissions to various hospitals in the city because of progressive shortness of breath, nonproductive cough, and generalized weakness of five years duration. She worked as a yarn threader in a textile factory for 16 years and retired in 1955. Physical examination revealed an elderly female

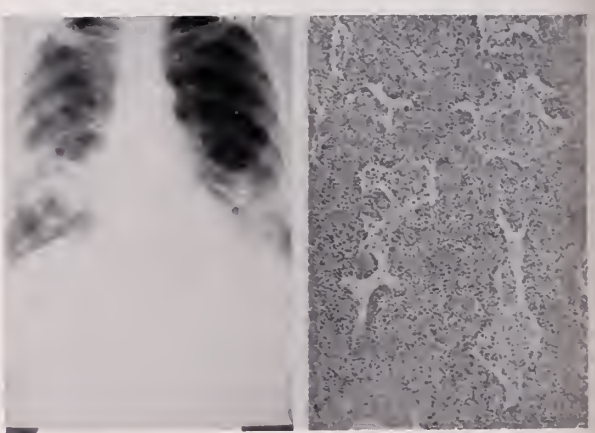


FIGURE 3

(Case 2) Roentgenogram showing diffuse nodular infiltration of both lungs. Photomicrograph in same case showing changes consistent with diagnosis of Hamman-Rich syndrome.

slightly dyspneic with no evidence of cyanosis or clubbing of the fingernails. Chest was symmetrical with diminished expansion of both lungs on deep inspiration. Breath sounds were diminished and rales were heard in the lower part of both lungs posteriorly. The remaining part of the lungs was clear. Heart was slightly enlarged with regular sinus rhythm. A soft grade II systolic murmur was heard over the aortic area and along the left para-

sternal border. Blood pressure 140/80. Repeated chest X-ray studies revealed diffuse pulmonary infiltration of both lungs with minimal amount of fluid in the right chest (Figure 3). Repeated studies, including upper and lower gastrointestinal series, intravenous pyelogram, bronchoscopy, bronchial washings, bronchogram, skin test, and sputum examination yielded no clue as to the etiology of this infiltration. Hemoglobin was 10.1 grams, white blood count 10,600 with normal differential. Fasting blood sugar 108 mgm., blood urea nitrogen 21.5 mgm. per cent. Sputum culture revealed pneumococcus in one occasion.

On August 11, 1960, under endotracheal anesthesia biopsy of the right lower lobe was performed. Histological findings were consistent with a diagnosis of Hamman-Rich syndrome (Figure 3). Post-

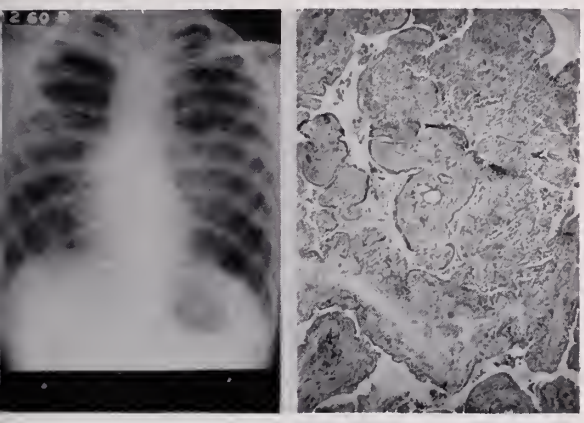


FIGURE 4

(Case 3) Roentgenogram showing bilateral fine infiltration with multiple small cystic areas. Photomicrograph in same case showing diffuse fibrosis and cystic areas consistent with congenital cystic disease of the lung.

operative course was smooth for the first eight postoperative days; however, she developed massive urinary infection and pyelonephritis which were adequately treated with antibiotics. She was discharged on September 6, 1960.

Case 3, E. G. — Miriam Hospital No. 89681. This was the fourth hospital admission of this fourteen-year-old girl with known cerebral palsy. She was admitted with a chief complaint of persistent cough of two years duration productive of a minimal amount of whitish sputum. Her three previous admissions had been for the same problem, and she had been treated with antibiotics on repeated occasions with no response. Repeated chest X-ray studies revealed diffuse infiltration of both lungs (Figure 4). This infiltration was more marked around the posterior segment of the right upper lobe. Repeated studies on her previous admission revealed no abnormal findings. Repeated sputum cultures for acid fast organisms and fungus were negative. Culture of the sputum revealed a few yeast and pneumococcus on one occasion.

Physical examination on her last admission revealed a slightly apprehensive girl in no acute distress with no evidence of any cyanosis or clubbing of the fingernails. The chest was symmetrical; scattered wheezes and ronchi were heard bilaterally. Heart was of normal size, regular sinus rhythm. Blood pressure 120/60. Laboratory studies revealed clear urine with specific gravity of 1.017. Blood studies including counts and smear, fasting blood sugar, blood urea nitrogen, total protein, calcium, phosphorus, and cholesterol were within normal limits. On February 7, 1961, under general anesthesia biopsy of the right lower lobe and parietal pleurectomy were performed. The right lung was completely replaced by many cystic areas varying in size from a few millimeters to a few centimeters. The right lung was emphysematous and completely replaced by fibrotic tissue. Histological report was pulmonary fibrosis and cystic degeneration (Figure 4). Patient had a smooth postoperative course, and she was discharged from the hospital on her ninth postoperative day in satisfactory condition.

Case 4, J. P. — Roger Williams General Hospital No. 204235. This forty-five-year-old white male, a diamond cutter for many years, was admitted with a chief complaint of dyspnea on exertion and generalized weakness. The patient had been in good health all his life. Two years prior to admission he developed rheumatoid arthritis of the upper extremities for which he was treated with corticosteroids.

Fluoroscopy and chest X-ray studies a year prior to his admission revealed no abnormal findings. Physical examination revealed a well-developed, well-nourished male with marked clubbing of the fingernails and moderate osteoarthritic changes of the fingers. Chest was symmetrical and well expanded, and scattered wheezes were heard bilater-

continued on next page

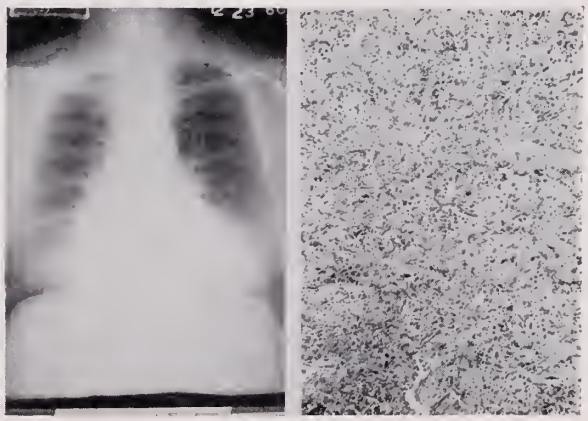


FIGURE 5

(Case 4) Roentgenogram showing generalized cardiac enlargement with diffuse infiltration of both lungs. Photomicrograph in same case showing pulmonary changes consistent with the diagnosis of rheumatoid arthritis.

ally. Heart was enlarged with regular sinus rhythm. No murmurs were heard. Blood pressure 130 70. Examination of the abdomen revealed no abnormal findings. Chest X-ray revealed generalized cardiac enlargement with diffuse infiltration of both lungs, more marked in the lower lobes (Figure 5). Laboratory studies were as follows: Hemoglobin 14.6 gm., white blood count 10,500, with a normal differential. Fasting blood sugar 114 mgm. Blood urea nitrogen 21 mgm. Serum glutamic oxalacetic transaminase 22 units. Uric acid 675 mgm. per cent. L. E. cell preparation was negative. Total protein 7.15 grams, albumin 3.40, and globulin 3.75 grams. Alkaline phosphatase 3 Bodansky units. Liver chemistry was within normal limits. Sputum smear and culture revealed no pathogenic organism. On December 28, 1960, under endotracheal anesthesia biopsy of the right lower lobe was performed. Histological findings were consistent with pulmonary changes of rheumatoid arthritis (Figure 5). Patient's postoperative course was complicated by congestive failure which was treated adequately with digitalis and diuretics. He was discharged from the hospital two weeks following surgery.

Case 5, Y. C. — Roger Williams General Hospital No. 210284. This was the fourth Roger Williams Hospital admission of this sixty-two-year-old white female, who was admitted with left sided chest pain, dyspnea on exertion, epigastric discomfort for three and a half months duration. Physical examination revealed an elderly female with diminished expansion and decreased breath sounds of the left chest on deep inspiration. The remaining lungs were clear. Heart was of normal size, with regular sinus rhythm. No murmurs were heard. A2 greater than P2. Blood pressure 150/80. Examination of the abdomen revealed no abnormal findings. Chest X-ray revealed marked pleural effusion of the left chest with diffuse infiltration of the right lower lobe (Figure 6). Laboratory studies revealed clear urine with a specific gravity of 1.015. Hematocrit 45 per cent, white blood count 8,600 with a normal differential. Fasting blood sugar 88 mgm. Blood urea nitrogen 20 mgm. per cent. Thoracentesis of the left chest revealed serous straw color fluid with a specific gravity of 1.015. Cell count of this fluid revealed many red blood and white blood cells. Sputum studies and complete gastrointestinal series were negative.

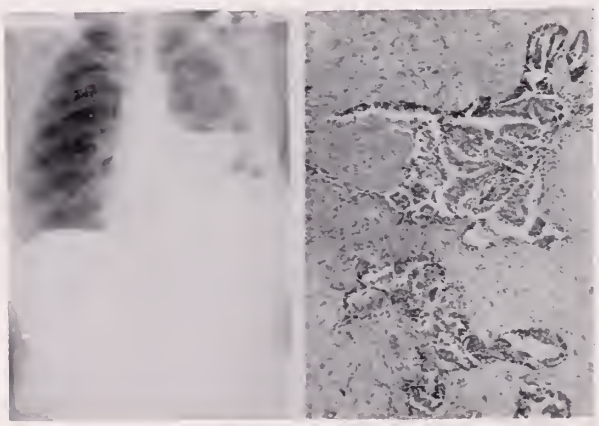


FIGURE 6

(Case 5) Roentgenogram showing diffuse infiltration of both lungs and pleural effusion on the left. Photomicrograph showing metastatic adenocarcinoma primary site pancreas.

On August 28, 1961, under general anesthesia biopsy of the right lower lobe and pleura was performed. Frozen section examination of the resected specimen revealed papillary adenocarcinoma (Figure 6). Exploration of the abdomen through a small incision in the diaphragm disclosed that the primary site of the carcinoma was the head of the pancreas. Patient's postoperative course was smooth and she was discharged from the hospital on her sixth postoperative day.

Case 6, H. L. — Miriam Hospital No. 93551. This was the first Miriam Hospital admission of this sixty-seven-year-old retired white male, who was admitted because of radiological findings of diffuse pulmonary infiltration, discovered on routine chest X-ray studies three months prior to his admission (Figure 7). The patient had no specific complaint except occasional postprandial epigastric discomfort. Physical examination was essentially negative. Laboratory studies were as follows: Hemoglobin 12.4 grams. White blood count 6,620 with a normal differential. Urine was clear with specific gravity of 1.025. Fasting blood sugar 12.4 mgm. Urea nitrogen 23. Transaminase 14 units. Alkaline phosphatase 7.1 Bodansky units, acid phosphatase 0.6 Gutman units, phosphorus 3.1 mgm., calcium 9.9 mgm. Upper gastrointestinal series revealed a slight deformity of the duodenal bulb. Intravenous pyelogram and retrograde studies

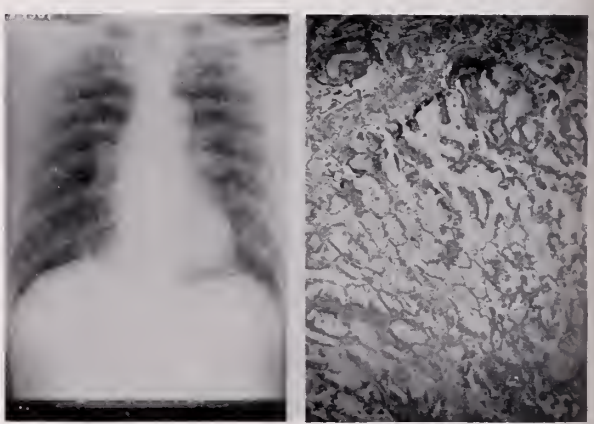


FIGURE 7

(Case 6) Roentgenogram showing bilateral diffuse nodular infiltration. Photomicrograph in same case showing metastatic adenocarcinoma primary site pancreas.

concluded on page 152

THIRTY-FIVE-YEAR REVIEW OF RHEUMATIC FEVER AND RHEUMATIC HEART DISEASE IN RHODE ISLAND* (1925-1960)

BANICE FEINBERG, M.D.

Author. *Banice Feinberg, M.D., Physician-in-Chief, Department of Pediatrics, Rhode Island Hospital, Providence, Rhode Island.*

THIS REPORT is based upon records from Rhode Island Hospital, a 600-bed institution containing a 95-bed pediatric unit, and also until recently a 50-bed convalescent hospital for children recovering from rheumatic fever (The Crawford Allen Memorial); and from the State Rheumatic Fever Program, which conducts a large clinic at Rhode Island Hospital. Since the State Program follows children to the age of 20 years, the statistics will be divided into children up to 20, and adults over 20.

In reviewing the records, many of which were microfilmed, dating back to the 1920's and early 1930's, special care in establishing the diagnosis was necessary. In all cases an attempt was made to follow as closely as possible the Jones criteria. Prior to 1940, the important criteria were polyarthritis, obvious organic valvular disease, pericarditis, and congestive failure. During this period, the children who were admitted appeared much sicker; after 1935, milder cases seemed to be the rule. This may be due to the fact that in the earlier period only the severest cases were hospitalized. With the use of sulfonamides and a better understanding of the role of the hemolytic streptococcus in the etiology of the disease, hospitalization upon diagnosis, regardless of the severity, has become the usual rule.

Of 3,243 admissions in the 35 years from 1925 to 1960, 1,349 were in children and adolescents under 20 and 1,894 adults over 20. In the childhood group 1,226, or about 90 per cent, were admitted with acute rheumatic fever and 124, or about 10 per cent, with complications of chronic rheumatic heart disease; in the adult group the figures were reversed, 421 with acute rheumatic fever and 1,473 with chronic rheumatic heart disease (Table I).

Between 1925 and 1930, 45 per cent of the admissions were in children and 55 per cent in adults. Between 1930 and 1950, the incidence was about equal with insignificant variation. In 1950 the admission rate in children began to diminish sharply so that by 1955-1960 only 27 per cent of the admis-

*Presented before the Spring Meeting of the New England Pediatric Society at Rhode Island Hospital, Providence, Rhode Island, May 24, 1961.

RF + RHD ALL AGE GROUPS 1925-1960	
TOTAL NO. ADMISSIONS REVIEWED	3243
CHILDREN (UNDER 20)	1349
ADULTS (OVER 20)	1894
CHILDREN - Dx ARF	1226
CHILDREN - Dx CRHD	124
ADULTS - Dx ARF	421
ADULTS - Dx CRHD	1473

TABLE I

RELATIVE INCIDENCE IN 5 YR. PERIODS		
	CHILDREN	*ADULTS*
1925-1930	99 - 45%	123 - 55%
1930-1935	181 - 52%	174 - 48%
1935-1940	176 - 49%	180 - 51%
1940-1945	204 - 51%	198 - 49%
1945-1950	310 - 52%	284 - 48%
1950-1955	212 - 37%	324 - 63%
1955-1960	167 - 27%	611 - 73%

TABLE II

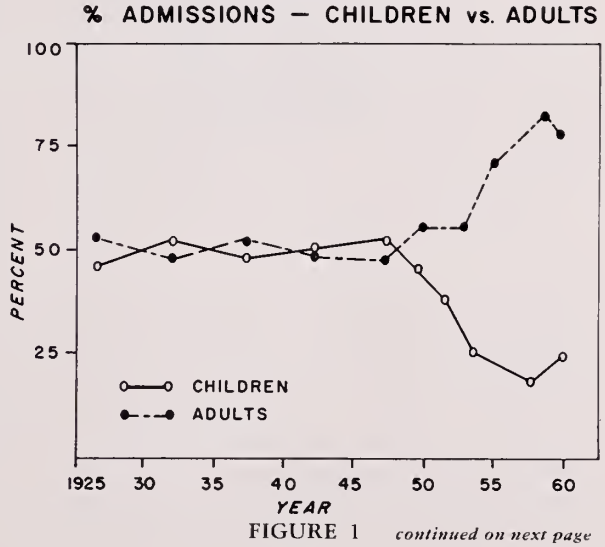


FIGURE 1

continued on next page

AGE OF ONSET OF RF (HISTORY) TOTAL NO. 1st ADMISSIONS 2,117			
UNDER 3	2	0.1%	
3 – 5	73	3.2	
6 – 8	557	25	
9 – 11	695	32	
12 – 15	355	16	
16 – 20	187	8	* INCLUDES 34 AUTOPSIES — OLD RHD WITH NO HISTORY OF RF
21 – 30	179	7	
31 – 40	129	5	
41 – 50	* 40	1.7	
51 – over	* 15	0.6	

TABLE III

MORTALITY – TOTAL 546		
	CHILDREN 69	ADULTS 477
1925 - 30	19 - 19 %	36 - 29 %
1930 - 35	14 - 7 %	38 - 22 %
1935 - 40	18 - 10 %	61 - 34 %
1940 - 45	8 - 4 %	47 - 24 %
1945 - 50	4 - 1.3 %	56 - 19 %
1950 - 55	4 - 2 %	116 - 35 %
1955 - 60	2 - 1.2 %	123 - 20 %

TABLE IV

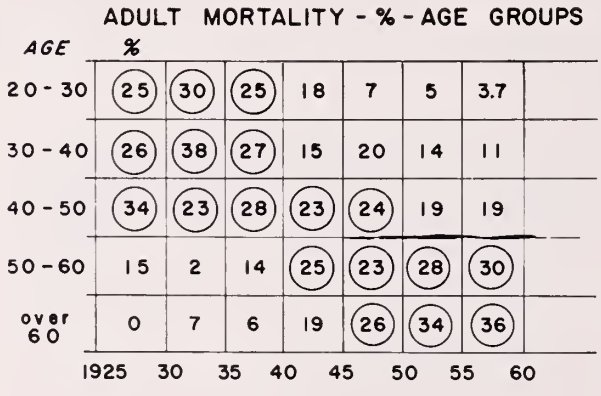


FIGURE 2

sions were in children, and 73 per cent, mostly with long standing heart disease, were in the adult group (Table II).

Figure 1 shows graphically the change in the picture of hospital admissions. The solid line represents the childhood admissions, and the broken line adult. Since the adult phase of the disease depends upon the incidence of rheumatic fever in childhood, it appears that in the foreseeable future the whole problem should become much less serious.

An attempt was made (Table III) to determine the initial onset of rheumatic fever. Histories were carefully studied. Also included were 34 autopsies in patients over 40 years of age which revealed positive evidence of rheumatic heart disease with no history of rheumatic fever. Of 2,117 first admissions, 3.2 per cent developed the disease under the age of 5 years; 25 per cent between 6 and 8; 32 per cent between 9 and 11; 16 per cent between 12 and 15; 8 per cent between 16 and 20; 7 per cent between 20 and 30; 5 per cent between 30 and 40; and 2.3 per cent after 40. This would point to the 5-15 year group as being the most susceptible.

There were 69 deaths in children and 477 in adults (Table IV). The death rate among children was highest in the 5-year period 1925-1930 (19 per cent) and began to drop appreciably in the 1930's to less than 10 per cent. By 1945 it had dropped to 4 per cent; and since 1945 it has been 2 per cent or less. The picture in the adult age group has been essentially unchanged, although in the last 5 years there appears to have been an appreciable drop of first admissions, doubtless representing newer and improved methods of handling complications of chronic rheumatic heart disease. The relative role in acute rheumatic fever in children of the administration of antibiotics and steroids, or a change in its natural history is very debatable.

The change in adult mortality is indicated graphically in Figure 2, beginning with the third decade of life, in 5-year groups. From 1925 to 1940 the third, fourth, and fifth decades were the most dangerous; and from 1940 to 1950 the fifth and sixth decades. Since 1950 the group over 60 years of age, the seventh decade and over, had the highest mortality.

The change in length of hospitalization in children is demonstrated by the experience in our new 32-bed Crawford Allen Memorial extended care unit (Table V). In the 1940's the average stay was 310 days; 1950-1955, 192 days; and since 1955, 104 days. The need for this unit has become so reduced that the original 50-bed unit located 16 miles away from the parent institution, Rhode Island Hospital, has been closed and sold, and a new, more modern, smaller unit for extended care of children in general has been built as part of the acute pediatric unit of the hospital.

The recurrence rate before prophylaxis was available was shown in an earlier study (Table VI). From 1925-1940 the recurrence rate in rheumatic fever in 195 cases was 26 per cent. These cases were from the Children's Cardiac Clinic at Rhode Island Hospital and from private practice.

Prophylaxis

The results of sulfonamide prophylaxis in rheu-

LENGTH OF HOSPITAL CONVALESCENCE CHILDREN UNDER 16	
CRAWFORD ALLEN MEMORIAL	
1940-1950	310 DAYS
1950-1955	192 DAYS
1955-1960	104 DAYS

TABLE V

RECURRENCE RATE IN R.F. 1925-1940	
CHILDREN WITH R.F. AT R.I.H. O.P.D.	147
FROM OTHER SOURCES	48
TOTAL	195
NO. OF CHILDREN WITH RECURRENCE	51 - (26%)

TABLE VI

matic fever first used in 1941 are significant. Of 96 children with rheumatic fever not receiving prophylaxis, 26 or 28.5 per cent developed recurrences; on the other hand, of 73 who received sulfonamides prophylactically, 4 or 5.4 per cent developed recurrences. Since 1949 oral penicillin, 200,000 units daily, has been used in all cases of positively diagnosed rheumatic fever with a recurrence incidence lower than 3 per cent.

Steroids

In Figures 3-7 are recorded the results of a study in 1951-1953 on the effects of steroids versus salicylates on the course of rheumatic fever in 36 controlled cases. Eighteen cases were on steroid therapy for 6 weeks and 18 on salicylates.

The comparative effect of salicylates and steroids on polyarthritis, graded according to severity, is shown in Figure 3. It will be noted that polyarthritis disappeared much more rapidly with steroids, within 2 days; while the salicylate group took about 5-6 days. In Figure 4 is shown the effect of these agents on the erythrocyte sedimentation rate (Ernstene-Rourke method), the normal being under 0.45 mm. per minute. The sedimentation rate in the steroid group returned to normal in 3-6 weeks, while the salicylate group took 6-12 weeks or more. Steroids exerted significant effect upon subsidence of fever. With steroids the temperature returned to normal within 1-4 days. With salicylates the drop was slower (Figure 5). There was very little difference in electrocardiographic changes in either group (Figure 6). Very little difference in residual cardiac damage was noted after 2 years (Figure 7). Cardiac damage was determined by evidence of X-ray enlargement plus significant murmurs. These youngsters have been followed for 7 more years with no appreciable change in the picture.

The results of a 12-year follow-up of 185 children in the Rhode Island State Rheumatic Fever Program is highly significant (Table VIII). These children had a positive diagnosis using the Jones criteria with murmurs graded 1-6. Of 108 children with grade 1 and grade 2 murmurs, there were

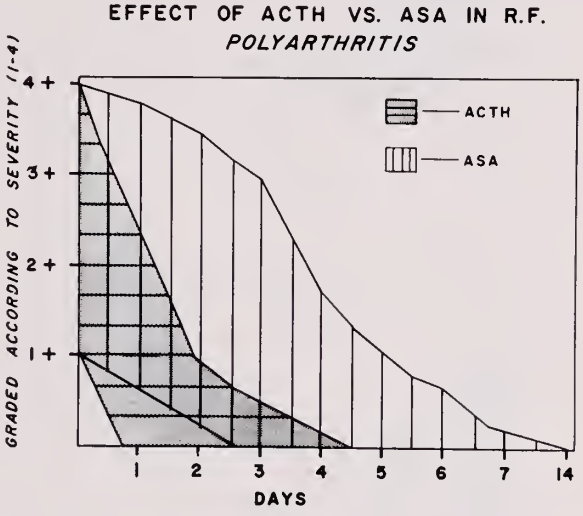


FIGURE 3

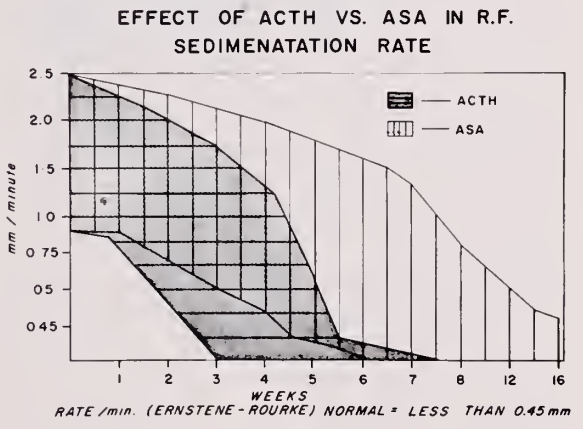


FIGURE 4

2 deaths, or less than 2 per cent; of 59 with grade 3 murmurs, there were 6 deaths or 10 per cent; and of 18 with grade 4 murmurs, 4 or 22 per cent. Forty per cent of the 108 children having grade 1 and grade 2 murmurs now have no audible murmurs or cardiomegaly.

Conclusions

From this study it appears that rheumatic fever is becoming less frequent and milder in form, and

concluded on next page

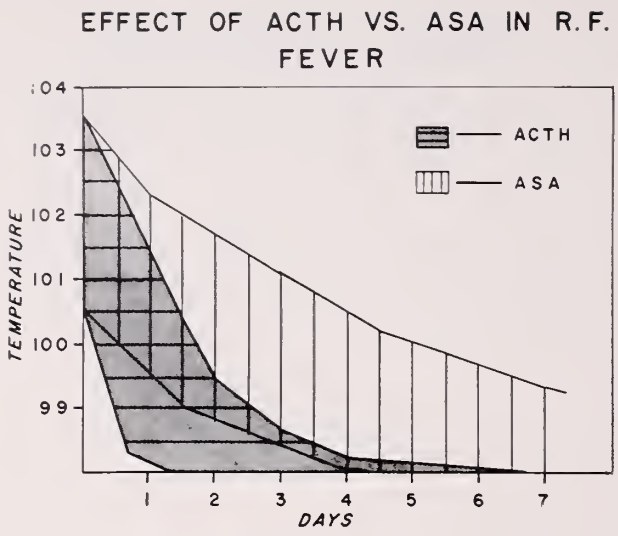


FIGURE 5

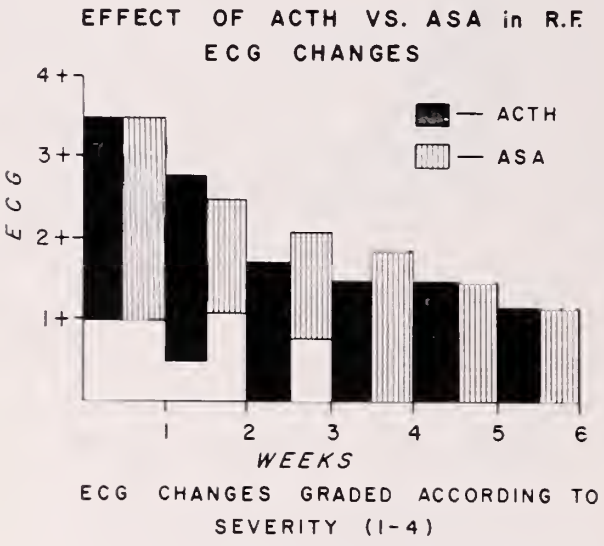


FIGURE 6

CHEMO-PROPHYLAXIS IN R.F. 1941-1949 NO. OF CASES OF R.F. AT R.I.H.	
STATE R.F. PROGRAM	138
OTHERS	26
TOTAL	164
NO. NOT RECEIVING SULFA	91
NO. DEVELOPING RECURRENCES	26 (27%)
SULFA PROPHYLAXIS	73
RECURRENCES	4 (4.4%)

TABLE VII

12 YR. FOLLOW UP OF 185 POSITIVELY DIAG. STATE R.F. PROGRAM CASES (MURMURS GRADED 1-6)		
GRADE	DEAD	%
1, 2 - 108	2	2
4D OF 108 GRADE 1, 2 NOW HAVE NO (M) OR CARDIOMEGALY		
3 - 59	6	10
4 - 18	4	22

SINCE 1942: *185 CHILDREN FROM THE STATE R.F. PROGRAM WITH POSITIVE Dx OF R.F. USING THE JONES CRITERIA, FOLLOWED FOR 10 OR MORE YEARS — THERE HAVE BEEN 12 DEATHS*

TABLE VIII

that life expectancy is increased. The role of steroids is still uncertain. Hospital convalescence has been shortened, and there is no longer the need for large convalescent units.

* * *

Grateful acknowledgment is made to Miss Lois Jomini, Medical Record Librarian of the Rhode Island Hospital, for her co-operation and in particular to Miss Mary Grover, Assistant Medical Record Librarian, who devotedly spent hundreds of hours in accumulating the vast amount of material over a period of several years necessary for this review.

Reference

[1]Jones, T. D.: Diagnosis of Rheumatic Fever. J.A.M.A., 126:481, 1944

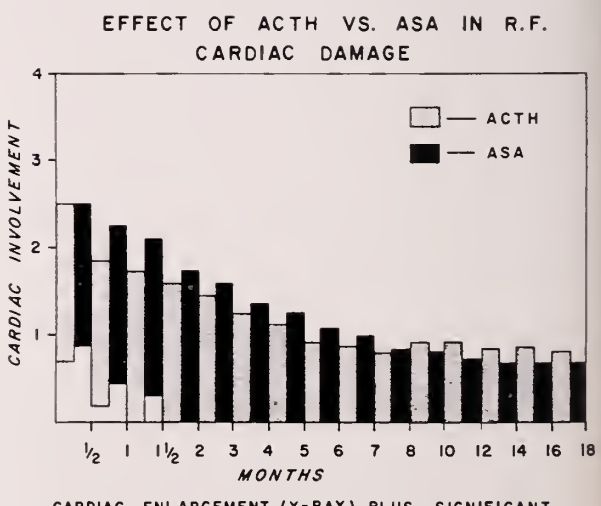


FIGURE 7

CONGENITAL ABSENCE OF THE GALL BLADDER

Report of a Case

ANTHONY V. MIGLIACCIO, M.D., AND ANTHONY J. MIGLIACCIO, M.D.

The Authors. *Anthony V. Migliaccio, M.D., Surgeon, Rhode Island Hospital.*

Anthony J. Migliaccio, M.D., Assistant Resident, Department of Surgery, Rhode Island Hospital.

A RARE FINDING in the biliary tree is the congenital absence of the gall bladder. Other anomalies of the biliary system have been found in ten per cent of autopsies.[5] Depending on the investigator, absence of the gall bladder (*per se*) varies in incidence from 0.03 per cent to 0.075 per cent of all autopsies. Gross states that more than 400 cases of atresia of the extra-hepatic biliary tree have been recorded. Of these, about one-sixth were associated with absence of the gall bladder. Thirty-eight cases showed normal hepatic and common ducts.

The earliest case was reported in 1701.[5] Muckmull mentions four cases in 6,600 autopsies.[4] Prior to 1900, thirty cases of this anomaly were reported.[2] Of these, twenty-four were found at necropsy. An adequate history was noted in twelve cases, and five of these had symptoms of gall bladder disease. Ten of the thirty cases were over 45 years of age. Since 1900, according to Dixon and Litchman, sixty cases were noted as of 1945, twenty-six being found at necropsy. Thirty-five (58 per cent of the sixty cases) were noted to have symptoms of cholecystic disease. Seventy-three per cent were more than 45 years of age, with the average age being 46.7 years. Their sex incidence was approximately 3:2, females:males. Bower reported an average age incidence of 48 years in a series of 31 cases.[1]

Latimer agrees with the average age but found a sex incidence in his entire series of 2:1, females:males. However, the autopsied specimens showed the males and females to be equal, while those operated upon had a 3.3:1 ratio, females over males. His deduction was that the anomaly had little relation to sex, but that the "symptomatology provoking exploration of the biliary tree in this entity followed the same sex ratio as does all surgical biliary disease."[9]

Embryologically speaking, the gall bladder begins as a local dilatation of the hepatic diverticulum, originating where the hepatic ducts become confluent.[3] This can be seen in a 5.5 mm pig embryo and hence its absence could possibly be caused by some effect on the development prior to this stage. Although the hepatic diverticulum is tubular, the gall bladder anlage maintains a solid state until the seventh week of fetal life. Thus, an absent gall bladder could result from failure of the anlage to form, or failure of the solid structure to become tubular.[5]

Symptoms in this disease are variable, usually being related to the biliary tree, and naturally are dependent upon the associated anomalies. As noted already, Gross found thirty-eight cases with normal hepatic and common ducts. (In fact, compensatory dilatation of the hepatic or common ducts was rarely seen with the absent gall bladder.) The absence of the bladder *per se*, did not in any way impair the health or digestive functions of these persons. Of the seventy-one cases mentioned by Latimer, thirty-four gave a history consistent with biliary tract disease.

Usually the routine gall bladder series offers little in the way of diagnostic value, the "non-filling" and the absent organ having comparable films. When, however, symptoms suggesting gall bladder disease are present and are severe enough, and a "non-filling" gall bladder is noted on X-ray, the surgeon is obligated to explore the patient after all other possible diseases have been ruled out. Once the anomaly is discovered, the surgeon must then attempt to determine the cause of the patient's symptoms. The following is such a case, operated upon by one of the authors (A.V.M.).

Case Report

M. P. was admitted to the Rhode Island Hospital on December 20, 1957. She was a seventy-two-year-old Italian widow who entered with complaints of nausea, vomiting, and diarrhea for three days. She had been in excellent health until one year prior to admission when she noted the onset of a 50-pound weight loss. Six months prior to this admission a gastrointestinal X-ray series showed "antral gastritis or ? neoplasia" and a gall bladder series showed a "non-functioning gall bladder."

Three days prior to admission she began to have "green diarrhea," and was unable to hold fluids in her stomach and frequently vomited. She was given

concluded on next page

anti-emetics and anti-diarrhetics to no avail, and she was admitted to the hospital. She gave a history of a generalized abdominal ache, but denied jaundice, melena, or hematemasis.

Family history, past history, and social history were noncontributory.

Physical examination: Pulse: 92, regular. Temperature: 98.6 F. Blood pressure: 15/100. She was a well-developed, obese, white female, dehydrated and alert. Examination of the neck revealed a substernal thyroid. The chest, abdomen, rectal, and neurological examinations revealed no pathology.

Initial laboratory findings: Hemoglobin: 16.0 grams. Hematocrit: 48 per cent. White blood count: 8,000 with polymorphononuclear leucocytes: 77; lymphocytes: 15; and monocytes: 6. Fasting blood sugar: 120 plus. Blood urea nitrogen: 48. Electrolytes were normal. Prothrombin activity: 54 per cent. Urine negative except for 1 plus protein.

Subsequent laboratory findings: Blood urea nitrogen: 18. Blood protein: 6.3. Albumin: 4.1. Stool cultures were taken.

X-rays: Chest: There was a large mass in the right upper mediastinum consistent with intrathoracic goiter. Barium enema showed marked extrinsic compression in the rectosigmoid and distal sigmoid against the sacral promontory incidental to a large pelvic mass. The mucosal pattern was intact. *Gastro-intestinal Series:* There was a small hiatus hernia, and there was prolapse of the distal antral mucosa into the base of the duodenal bulb.

Course in Hospital: The patient's obesity precluded an adequate pelvic examination. In view of the fact that the patient was unable to take anything by mouth and had green diarrhetic stools associated with abdominal pain, exploratory laparotomy was performed. The initial incision was in the midline suprapubically in anticipation of finding the pelvic mass "noted" on the barium enema. No pelvic mass of pelvic pathology was noted. The upper abdomen could not be explored satisfactorily. A right subcostal incision was then made. There were many dense omental adhesions to the undersurface of the liver. These were dissected free. The gall bladder could not be visualized. What would normally be a gall bladder fossa was a narrow fibrous ridge. The common duct was then completely explored without any evidence of a gall bladder. A fibrous band was found crossing over the hepatic duct, causing some compression of that duct leading towards the hepatic artery. This was dissected free and excised. An incidental appendectomy was performed. Examination of the remainder of the viscera was negative. She had an uneventful post-operative course.

Two days postoperatively the stool cultures grew out Salmonella. This organism probably accounted for the patient's symptomology; and she was treated accordingly. Her symptoms subsided and she was discharged on her tenth postoperative day.

Three years after this procedure the patient suffered a perforation of a gastric carcinoma which shortly thereafter caused her demise. Autopsy findings confirmed the initial operative findings of agenesis of the gall bladder. The only other anomaly found in the hepatic ducts was that the common duct entered the duodenum well into the second portion, "much farther distal than usual."

SUMMARY

We have reported a case in which no gall bladder could be found during an operation for what was reported to be a nonfunctioning gall bladder by the roentgenologist. An autopsy three years later confirmed agenesis of the gall bladder.

The literature on the subject has been briefly summarized.

References

[1]Bower, J. O.: Congenital Absence of the Gall Bladder, Ann. Surg. 88:80, 1928

[2]Dixon, C. F., and Lichtman, A. L.: Congenital Absence of the Gall Bladder, Surgery 17:11, 1945

[3]Patten, B. M.: Human Embryology. Second Edition. The Blakiston Company, N. Y., 1953. P. 483

[4]Mackmull, G.: Congenital Absence of the Gall Bladder in Man, Ann. Surg. 91:789, 1930

[5]Latimer, E. O., et al: Congenital Absence of the Gall Bladder; Report of 3 Cases, Ann. Surg. 126:229, 1947

[6]Gross, R. E.: The Surgery of Infancy and Childhood. W. B. Saunders Company, Phil., 1953. P. 538

If medical progress were to be measured solely in terms of published work, the number of journals in existence would be a source of satisfaction and pride. It must be remembered, however, that each journal provides work for a council, an editorial staff and board, several editors, and sub-editors, numerous reviewers and writers, no doubt, of additional dialogue. The time spent in research is actually reduced by the man-hours devoted to academic journalism. And if all concerned were to read each others' journals (as would seem essential, to prevent duplication) they would clearly have time for nothing else.

PROFESSOR C. NORTHCOTE PARKINSON, in an address to the American Federation for Clinical Research, at Philadelphia, January, 1962.

Sesquicentennial Celebration Dates

SCIENTIFIC MEETING

May 8 and 9, 1962

Marvel Gymnasium, Brown University

THE PHYSICIAN IN 1961*

RUSSELL P. HAGER, M.D.

The Author. *Russell P. Hager, M.D., President, 1961, the Kent County Medical Society.*

FRIENDS, fellow doctors, countrymen, lend me your ears. I come to review a serious situation challenging medicine which has developed during the past year and not to whitewash or praise doctors. The evil that doctors do, makes headlines in our daily papers. The good is most often ignored or accepted as traditional. So let it be with medicine.

Certain noble labor union employees have told you of doctors' misdemeanors. If these things were so, they were grievous faults and grievously are all doctors answering for them. Medicine is my career and doctors are my friends, faithful and just to me: with labor spokesmen we are greedy and dishonest, taking advantage of Blue Cross-Physicians Service and other insurance plans; and these spokesmen and labor leaders are honorable men.

Our doctor has been followed through high school and recommended by those who come in contact with him for admission to college. He has been recommended not only for ability, but character as well. During four years' training in college, he is again carefully evaluated by deans, professors, and instructors; all of whom must recommend him as to character and integrity, as well as professional ability, before he is accepted to medical school. In medical school, working closely with teachers, instructors, and colleagues who have every opportunity to observe character traits, intellectual honesty, as well as ordinary honesty, our doctor-to-be is carefully evaluated and must be recommended prior to postgraduate training as intern and resident. In the hospital, living in a hospital community, the doctor can be observed twenty-four hours a day, under all types of conditions; and his character well evaluated. To be a practicing physician and member of the medical society in good standing, he must be recommended at all levels; high school, college, medical school, and hospital. During all this time our doctor is paid little, nothing, or actually pays from his or his family's resources for a meager subsistence. Are those who subject themselves to this type of scrutiny, to this low grade of economic existence, greedy or dishonest? Yet, professional labor spokesmen say these doctors are greedy and dishonest.

During the past year, doctors in our Kent County Medical Society have served in outpatient departments in the various hospitals within this state without any pay. They have operated without recompense on ward patients, have made daily rounds, have served in our accident rooms for those who cannot pay. Is this greed? Is this ambition? Is this dishonest? Greed should be made of much sterner stuff. When the poor had need of them, our doctors have helped. In many clinics as well as in their own offices, our doctors gave their own time with no personal gain or pay. Does this seem greed or dishonesty? Yet these labor professionals say these doctors are dishonest. I speak not to disprove what these critics speak, but here I am to speak what I do know.

The public did respect physicians once not without cause. What cause withhold the public then to respect them now? I judge not that men have lost their reason. But yesterday, the word of a doctor might have stood against the world. Now his reputation has been besmirched in the daily press and none so poor to do him reverence. Good friends, sweet friends — they that have lowered the respect of the public for physicians are honorable men. What private griefs they have, alas, I know not. What made them do it? They are wise and honorable and will no doubt with reason answer you.

Until now the American Medical Association has, to an extraordinary extent, regulated its own affairs with little outside control or interference by government. There is now a threat in this country toward concentration of power, toward an over extension of government and toward a socialistic state. I am informed that there is a handbook for political education sent to local union chapters by the AFL-CIO's efficient Committee on Public Education (COPE). It has a prime objective to discredit doctors and to discredit their opposition to socialization of medicine. The handbook advises short repetitive statements to seek by their very repetition to convince the unthinking, regardless of the truth. A quotation from the book apropos of

concluded on next page

*Retiring President's address delivered at annual meeting, December 7, 1961.

this philosophy: "I think that life is not too long, therefore, I deem that many people will read a song who will not read a sermon." Scholarly study and logic cannot refute the recent dire accusations made to drive into the minds of the public a disregard for the integrity of the physician. How well the system has worked is shown by the loss of respect for the medical profession by college students. THE PROVIDENCE JOURNAL recently quoted a well-known college officer as saying that fewer of the best qualified college graduates are interested in medicine for a career because of the loss of status of the physician. In 1950 the standing of applicants for medical schools was as follows: 43 per cent A students; 40 per cent B students; 17 per cent C students. In 1959 only 15 per cent were A students; 70 per cent B students; and 15 per cent C students. In 1955 the point average of applicants was greater than 3.5. In 1960, the point average dropped to 3.2. In 1950 there were 22,000 applicants for American medical schools. This number had fallen to 14,400 in 1960. In Great Britain medicine has become a political tool, and the cost had doubled from 1950 to 1960.

Medicine feels that *need* should be treated as such, and that the majority of individuals in the state ought not to require welfare services. It believes in the independence of the individual, and it seeks to raise the welfare education and health of the one third less gifted, less healthy, and less able. Labor and politicians will bargain, attempting to get medical care at cheaper and cheaper cost. They assume that cheaper medicine will be the same type of medicine; but will it not be like the man with a horse who wanted to board it with a farmer? This man reasoned, cajoled, and badgered. The farmer's price went down and down until the farmer would no longer accept a reduction in his fee for caring for the horse. As final argument, the man said, "Just think! While taking care of my horse you can collect the manure, sell it and so reduce your fee." The farmer sadly shook his head and stated that at the fee already suggested, there would be no manure.

As physicians we feel that attempts to make medicine cheaper and cheaper will reduce the quality of medicine. We wish the public to be protected from harm and from greed by the avaricious. If there is to be supervision of medicine, we sincerely hope that it will be by honorable men with reputations at least equal to that established by most physicians prior to their right to practice medicine.

I have neither wit, nor words, nor worth, nor power of speech to appeal to the general public. I tell you that which you yourselves do know. I show you the deep wounds inflicted in the reputation of physicians and bid them speak for me. Labor spokesmen will not flee like Brutus and Cassius. We cannot through oratory overcome their claims. However, I charge each of you, members of our profession, so to discharge your responsibilities that there can be no valid outcry that government must enter to cause you to perform adequately for the public good. So order your life and practice that you may take pride in your reputation. Discharge your responsibilities to the public so that there will be a better understanding between the men of business and labor, and the medical profession. Then being sure of your facts, state your case vigorously and often. Only thus will the reputation of the physician be re-established.

LUNG BIOPSY

concluded from page 144

were essentially negative. Skin tests for fungus, and tuberculosis were negative.

On September 18, 1961, under general anesthesia, a small segment of the left lower lobe was removed. Frozen section revealed adenocarcinoma (Figure 7). Limited exploration of the abdomen through a small incision in the diaphragm revealed carcinoma of the head of the pancreas. Patient's postoperative course was smooth, and he was discharged from the hospital on the fifth postoperative day in satisfactory condition.

Discussion and Summary

The indications for lung biopsy fall into groups: (1) Chronic and diffuse pulmonary disease where simple diagnostic techniques have failed to establish the diagnosis, and (2) Selected cases where from the medical-legal aspect possible occupational disease is of importance. In these two groups of patients lung biopsy offers a quick and efficient method of establishing the diagnosis and may avoid prolonged and costly hospitalization. The procedure is not recommended to be used routinely. In many patients accurate diagnosis can be established by less radical measures, such as skin test, bacteriological studies, cytological examination, and scalene node biopsy. Lung biopsy is recommended only where the usual measures have failed to establish the diagnosis. In six reported patients with diffuse pulmonary disease accurate diagnosis was established by lung biopsy. There was no mortality and minimal morbidity. The majority of patients were discharged from the hospital from five to seven days after surgery.

REFERENCES

[1]Klassen, K. P.; Anlyan, A. J., and Curtis, G. M.: Biopsy of Diffuse Pulmonary Lesions. Arch. Surg., 59:694, 1949

[2]Chase, H. P.: Lung Biopsy for the Diagnosis of Disseminated Pulmonary Disease. Am. J. Surg., 89:166, 1955

[3]Andrews, N. C., and Klassen, K. P.: Eight Years' Experience with Pulmonary Biopsy. J.A.M.A., 164:1061, 1957

[4]Smith, J. W.; Parson, H. G., and Daniels, A. C.: Scalene Node, Parietal Pleura and Lung Biopsy in the Diagnosis of Intrathoracic Disease. J. of Thoracic Surg., 37:611, 1959

[5]Effler, D. B.; VanOrdstand, H. S.; McCormack, L. J., and Gralendo, H. A.: Lung Biopsy. Am. Rev. Tuberc., 71:668, 1955

PHYSICIANS SERVICE IN 1961

Report of the President, CHARLES J. ASHWORTH, M.D., *at the Thirteenth Annual Meeting of the Corporation of the Rhode Island Medical Society Physicians Service, January 29, 1962*

IT IS EXTREMELY DIFFICULT to select a single achievement or challenge as the salient event of the year 1961. Perhaps the best summary would be that 1961 was a year of many challenges and many achievements, with an ever-increasing complexity of issues and problems facing your Physicians Service Plan.

Yet, while all these challenges — many of them extremely controversial — were being faced daily, our basic task of paying surgical and medical bills was being carried on with even greater efficiency and service.

The fundamental objectives of your plan are to enroll as many people as possible, increase the effectiveness of the plan through improved benefits, and provide its services at the lowest possible cost. It is somewhat ironic that in this year of controversy the plan has recorded even greater achievement in meeting these goals, and continues to lead all other states in the nation.

Today — and every working day — your Physicians Service Plan processes an average of 1,200 claims. The total number of claims processed this year will be almost 300,000. This fact alone is testimony to the value and impact of your plan in Rhode Island.

We have pushed ahead with our basic goal of enrollment, and closed the year with an all-time high membership figure. This accomplishment, when we had no Direct Enrollment campaign to enroll new members, is strong evidence of the continuing public confidence in our plan to provide the best protection against the cost of surgical-medical care.

We were able to increase the number of people covered under Plan B, and provide an additional half million dollars more in paid claims last year. After suffering losses for two years in a row, 1961 saw us end the year with a modest gain. As a result of the self-adjusting rating system established in late 1960, and reapproved after modification in 1961, we have been able to overcome our losses during the early part of the year, make a slight over-all reduction in rates, and still show a gain for the year.

Public confidence is demonstrated through our enrollment gains for the year. There is also an encouraging note of confidence by the medical profession, as shown in the fact that at the close of 1961 a total of 996 doctors were "participating physicians" in the plan, which is an increase of 20 physicians.

Despite the crescendo of publicity, public hearings and related issues, we have made substantial progress in other areas during the year. To mention a few, we have now provided a monthly billing system for our Direct Pay subscribers, our new Major Medical program is now in the contract and rating stage and should be ready to offer to groups within months, we have assumed local administration of the Federal Employees Supplemental (Major Medical) program, and we have made many internal improvements to provide further assurance that benefits will be used to the best advantage.

This brief listing is just part of the evidence of the increasing complexity and demands for additional services. Looking to the future, it is obvious that we must progress more in these and other areas in order to meet the increasing challenges of the changing times.

As you will note on your statistical summary sheet, there was a slight increase in the operating cost ratio last year, from 5.5 per cent of income to 5.8 per cent of income. This is still the lowest cost ratio of any state in the nation. But it is probable that our operating expenses will increase in the future if we are to meet the challenges of greater service, new areas of coverage such as Major Medical, and assurances that benefits are used wisely. To meet these objectives will take additional people. In many cases, over-all savings of plan dollars and total outgo will result, but it will still increase our operating expense column.

Despite the fact that we have been able to provide more service to more people, increase our enrollment during a very difficult period, and expand our operations and benefits in many areas, it has also been a year of criticism — criticism from some segments of the public and even criticism from our own profession.

Some of the criticism is obviously unjust, unfounded, and born out of ignorance of the purpose and operation of the plan. However, some of the

continued on next page

criticism may be constructive and helpful — it is my hope that we will not be blinded by our own corporate ego and past record of excellence and reject a constructive suggestion, no matter what the source. Certainly we do not represent the ultimate in perfection nor do we profess to know all the answers in this complex business.

Ours is a dynamic society, and becoming more so with every passing year. It is no longer possible for us to rest on our laurels with the proclamation that "we have always done it that way," or with the premise that a certain practice or range of benefits that was adequate in past years will be adequate today.

As physicians, we see constant evidence of progress, improved methods, and change in the practice of medicine. This same dynamic situation exists in medical economics. In our early days, many of us looked upon our plan as one for the poor, semi-indigent or medically indigent. But today we are in a period of rapidly expanding demands from the public to purchase their total health care through prepayment.

To exist and progress in this type of social environment, we cannot remain static, providing only resistance to change. It is vital that your Physicians Service Plan, which is a direct reflection of the medical profession's role in medical economics, must show positive leadership through constructive programs to provide better prepaid health care.

This philosophy was contained in the very founding of the Physicians Service Plan. It is this progressive thinking that is behind the development of our own Major Medical program, which will cover a much wider range of health care benefits.

One of the most pressing medical economic issues of our time is that of health care of the aged. It is a fact that in Rhode Island we have a record of voluntary coverage that is outstanding in the entire nation. More than 75 per cent of the eligible population over age 65 is enrolled in Physicians Service, and over 90 per cent in Blue Cross, with the same rates as younger people. In fact, these members are even subsidized on a voluntary basis with no tax money involved. This record, coupled with a comprehensive national program for the aged recently presented by the American Medical Association and the Blue Shield Plans and the American Hospital Association and the Blue Cross organizations, represent positive steps in the direction of an answer to this vexing human problem.

However, in all the issues before us at this time —including the composition of our Board of Directors—I strongly urge you to make certain that our actions demonstrate that ours is a position of enlightened interest, and not action that may be interpreted as being selfishly motivated.

It is our intention to do our best to answer criticism through deeds — through continued improvement of the plan to provide greater service to the public and the medical profession. In order to achieve this, it will take even greater co-operation and support from the entire medical profession during the coming year. Our decisions are difficult and undoubtedly will not meet with unanimous popularity. This will call for more clear thinking and calm deliberation than ever before in our history. It is imperative at this time that we maintain a unity that will defy any attempt at encroachment — only in this manner can the practice of medicine embrace the financial problems of health care with equity, honor and dignity.

Professional relations, as well as public relations, have a different meaning to different people. But if these relations deteriorate to an exercise in manipulation, our efforts to perform a service to the public and our profession are seriously diluted.

In the realm of public relations, no one would deny, I am sure, that formal participation in the Physicians Service Plan has improved the profession's status in the community. While the basic ideals of medicine are contained in the physical and spiritual services a doctor renders, the economic services of the plan also play an important part in our community service.

The very survival of the voluntary medical profession depends, in no small way, upon the success we can achieve in maintaining an effective balance between ethical ideals and economic needs. The embodiment of this principle lies in Physicians Service, which provides the means or expression of our sponsoring medical society's intelligent responsibility in this area of concern.

It is my conviction that our professional relations are improving. Personalities, outside pressures, and insignificant issues should not lessen or detract from such progress as:

— The more effective rapport which has been developed with participating physicians, as evidenced by the increase in the number of doctors who participate in the plan.

— The development of an efficient, rapid basis of payment for the physician's services.

— In cases of an unusual nature, the process of "Individual Consideration" for adjudication of individual claims.

However, the Physicians Service contract, like all other simliar prepayment plans, must have many regulations, exceptions, and complexities. To the physician, these regulations may seem tiresome and a detraction from the basic practice of the healing arts. Yet, today it is vital that physicians have a knowledge of what their plan provides and does not provide, as well as the more detailed regula-

concluded on page 156

A DOCTOR SPEAKS...

(The following is excerpted from a report which Dr. Meyer Saklad, President of the Medical Staff Association of Rhode Island Hospital, gave on December 6, 1961, at the meeting of the Corporation of the Hospital)

AT THIS MEETING of the Corporation of the Rhode Island Hospital are assembled people who are especially concerned with hospital care of the sick. In this room are representatives of the community, of the governing body and of the medical and nursing staffs of this hospital. Much has appeared in the press concerned with hospital utilization. As interested individuals we should be properly attentive to criticism. Wherein such criticisms are valid, or constructive, we should change. ... We should, however, be strong and resist pressure for change when such change may not be in the best interest of the patient.

Hospital stay is expensive. The newer drugs, improved instruments, better nurses and doctors and a better chance of survival cost a lot of money. Hospitals have been accused of inefficiency. Wherein inefficiencies in hospital business practices exist they should be corrected. Inefficiencies in patient care cannot be easily remedied. One cannot readily transfer the genius of modern-day efficiency experts from the factory to the bedside. I spent an interesting two hours not many years ago on a flight from New York to Chicago sitting beside an efficiency expert. He was going to revolutionize surgical practice. He believed that operations should be standardized. He was going to make up pre-packaged surgical kits of the instruments used in operations; one for removal of an appendix, one for removal of a gall bladder, one for the removal of the stomach, etc. The instruments would be arranged in the sequence in which they were to be used and thus much time would be saved. More patients could be turned out per operating room per hour. Costs would be reduced. It was a surprise to him to learn that no two patients are alike. He did not know that there are several ways of removing a stomach, for example. He did not know that the one particular type of operation best for the patient is that which may need to be determined after the diseased process is visualized, in conjunction with consideration of the patient's physical state, his age and his ability to tolerate successfully a particular operation. One cannot streamline patient care as one does automobile production. One day last week I visited one of our leading industrial plants. Here they were turning out about 14,000 of a particular unit per day. For over-all efficiency it was felt that there should be a certain degree of wastage. I asked my guide the number of rejects and he said up to 15 per cent of the product was wasted. In another area a machine was pouring out a molded product of plastic. That portion of the production not satisfactory was put back in the hopper to be done all over again. Efficiency in patient care cannot be so easily obtained. The care of a patient cannot be automated. Tolerance of poor results is unthinkable and, further, we have no hopper with which to reprocess humans.

Hospitals have been accused of having excessive equipment. What constitutes excessive equipment? I do not know, but I do know what constitutes an insufficient amount of equipment. I think you should know that one of the most important things which has been learned recently is that death is reversible. In a significant number of instances a heart which has stopped can be made to start again. A patient who has ceased breathing can be made to breathe again, provided efforts to do so are initiated within seconds to a minute or two of the time of death. This can be done only if the patient, properly trained personnel and the right equipment are at the same place at the right time. If the patient dies and the proper personnel to effect resuscitation are present but the equipment is not, then that hospital is inadequately equipped. To save money by pooling certain types of equipment in another hospital would be expensive in terms of lives lost. To have such equipment immediately available at areas where it may be life saving — the Accident Room, Operating Room, patient units, etc. would be very expensive. Should hospitals, however, delay purchase and distribution of such equipment because it would be reflected in elevated hospital costs? I assure you that the above is but one example of several types of equipment which would save lives could it be purchased in sufficient numbers.

It has been truly said that three Providence hospitals have heart-lung machines, and it has been further stated that "qualified opinion is that one would suffice." These machines are expensive. I should tell you also that the use of these machines requires trained teams. Frequent and regular test

concluded on next page

runs are required to keep the machines and people fit and ready. Physicians on these teams give of their time and energy. In short, heart-lung apparatus and their workings are very expensive undertakings. This investment, however, has paid off in phenomenal dividends: Dividends not in money, but in increased knowledge and in the development of technics, limited by no means to heart surgery. The heart-lung machine is being rapidly extended into other fields of treatment. It may revolutionize the treatment of certain ordinarily fatal conditions. Blessed, then, is the community which may have three heart-lung machines and three trained teams to employ them. The example of the heart-lung machines could be extended into other areas. Should hospitals cut back these programs because they increase costs? If so, the community will surely be deprived of an investment in improved health.

We hear much of over-utilization. We are told some patients come in for procedures for which under "normal" circumstances they would have stayed at home, or had done in doctors' offices. What is "normal?" At one time, and not too many years ago, patients had major surgery on the kitchen table. The great majority of babies were delivered at home. A certain number of people in this room have had their tonsils taken out in their kitchens. Fractures were reduced in doctors' offices. This is no longer normal. It should be normal to do what is proper for the patient's welfare. I believe it is proper for the patient to go to the hospital for the improved medical care that he can obtain there. It has been said that prepaid insurance plans have led to increased use of hospitals. I think that this is proper. I think that in terms of patient comfort, pain relief and safety, increased utilization is strongly indicated. It is unfortunate that economic pressures are such that they may be reflected in patient care. It is sad to contemplate that poor understanding of hospital and medical care may result in under-utilization. This would be tragic.

PHYSICIANS SERVICE IN 1961

concluded from page 154

tions governing the plan benefits. Knowledge of medical economics is today an inherent part of the practice of medicine. I have said this before, but it bears repeating. In my mind, it is as important to know the details of your plan regulations as it is to know how to practice medicine.

Once again, I want to express my deep appreciation to the members of the Board of Directors, both the professional and nonmedical members, who have given so generously of their time during this year of challenges. To the committees of the Board as well as the committees of the Rhode Island Medical Society, and the doctors who have served on the Claims Committee and Professional Advisory Committee, go my personal thanks for support. I also want to pass on my special thanks to Arthur F. Hanley, our acting executive director, who has borne the brunt of administrative responsibility of the plan since the illness of Stanley H. Saunders last year.

In this presentation of issues, statistics, and future problems, I must conclude on one of the most significant and yet saddening events of the year — the illness and recent death of Stanley H. Saunders, our founding executive director.

Behind all the records of service I have cited tonight has been the drive, dedication, leadership, and years of tireless effort of Stanley Saunders which made this plan outstanding in the nation.

While he is not with us in person tonight, Stanley Saunders is with us in the record of achievement I have presented, and the result of his life's work is embodied in the 585,000 persons who are protected by this plan. In the words of Motley: "Deeds, not stones, are the true monuments of the great."

I need not point out to this audience that a new medical school cannot be purchased like a can of beans simply by presenting cash. A tremendously complicated planning process is required, followed by a sustained construction program and the establishment of a faculty. It takes about ten years from the initial planning stage to the production of the first graduating class by a new medical school.

. . . CONGRESSMAN JOHN E. FOGARTY in an address to the 58th Annual Congress of Medical Education, at Chicago, February 3-6, 1962.

Curran & Burton, Inc.

INDUSTRIAL
AND WHOLESALE

COAL **OIL**

17 CUSTOM HOUSE STREET
PROVIDENCE, R. I.
DExter 1-3315

Editorials

AIR POLLUTION — PUBLIC AND PRIVATE

As the span of life has lengthened and infectious diseases and other causes of early death, with the notable exception of traffic accidents, have taken a diminishing toll in the middle years of life, more attention must be centered on those conditions that take many years to develop and are seen most often in the elderly. These illnesses, while for the most part they do not cut a man down in his most productive years, sharply limit the time left to him when he nears his threescore years and ten. In many instances they substitute for a vigorous old age a prolonged period of progressive invalidism that has little to make it preferable to an earlier and quicker demise.

One of the most distressing conditions in this category is chronic pulmonary disease. Chronic bronchitis and intrinsic asthma, chronic tuberculosis, and bronchiectasis all fall into this group. These are due primarily to infection. More important than these, however, are two great killers in which atmospheric pollution appears to play a most important role. These are bronchogenic carcinoma and obstructive emphysema. There is ample evidence that both of them have shown a striking increase in the last half century, an increase of such great proportions that the longer duration of life of the average citizen cannot explain it.

Many studies have been made as to the relationship of general atmospheric pollution by the discharge of waste matter in industrial smoke, by automobile exhaust gases, and by other types of air contamination to the occurrence of these conditions. This is particularly true of its relationship to squamous cell carcinoma of the bronchi. Some of the results of these studies have been suggestive. Another condition which is definitely due to air contamination with irritating substances is pneumoconiosis, chronic lung disease due to the inhalation of various forms of dust. This of course is related to certain occupations and industries. Dusts containing silicon are particularly harmful as are dusts in which are particles of asbestos or beryllium. Though these irritants produce characteristic and serious pulmonary damage, it cannot be said that they are causes of either carcinoma or chronic obstructive emphysema. The relationship of the ordinary contaminants found in the atmosphere in which the average city dweller lives to pulmonary cancer and to emphysema rests on suggestive evidence that is far from conclusive. However, it seems quite probable that some relationship exists.

In contrast to the rather tenuous connection between public air pullution, to which every individual who lives in an urban area is exposed, is the definite effect of the private pollution to which every person who inhales tobacco smoke subjects himself. That this is a most important causative factor in the production of our two killers appears to the unprejudiced person to be beyond question. From the publication of the pioneer studies of Evarts Graham and his group, and the investigations, too numerous to mention, that have been carried out since, the relationship between cigarette smoking and the development of squamous carcinoma of the bronchi is clear. Reluctance to accept this idea is based on the fact that those who are heavy smokers are inclined to resort to wishful thinking to bolster their hopes that the situation is not as bad as it appears, and also on the frantic efforts of the tobacco industry to muster evidence on the other side.

When it comes to the question of chronic obstructive emphysema we are dealing with a still more important subject, in that it affects many more individuals than does bronchogenic carcinoma. The wards of the general hospitals and domiciliary institutions are filled with pulmonary cripples with twenty or more years of cigarette smoking behind them.

The outlook is bleak. Nowadays many teenagers are already confirmed smokers on the way to becoming addicts, and the occurrence of crippling obstructive emphysema in a man in his forties is not a very rare sight. Chain smokers among women are all too common, and they too are appearing in hospital wards in the late stages of this disease.

In the judgment of the *Journal* it is time for our profession to do something about this. Physicians generally should make the facts clear to their patients, and those among them who have become addicts should at least shift to pipes or cigars and give up inhaling tobacco smoke. Although this

continued on next page

would probably have no effect in the prevention of the cardio-vascular damage from nicotine, it would at least tend to minimize the lethal effects of the smoke on the respiratory system. Hospitals should adopt more definite rules as to smoking by patients and should not condone it on the part of physicians when on ward rounds or in clinics.

When "chain smokers" occupy such positions as university administrators, physical education instructors and the like, one can hardly blame American youth for emulating those to whom they look for guidance. Physicians, however, who are in a position to understand the facts and to whom the public has a right to turn for leadership in matters of health, have the deepest obligation to do all they can to counteract this menace to public health.

NURSING HOMES: A FUNCTIONAL RE-EVALUATION

THE INCREASING DEMAND for nursing home beds calls for a review of the entire problem and the related problem of domiciliary care for the aged. The nursing homes are commonly large multi-story houses in older parts of town, abandoned as impractical for family use, but useful because of the number of bedrooms for conversion to homes for convalescents or the chronically ill. Often corridors and doors are too narrow; there are no elevators; and space for medical equipment or treatment rooms is inadequate or nonexistent. "Many nursing homes," says John A. Hackley of the Illinois Public Aid Commission, "have become places in which to die — whether death takes three or thirty years to occur — because of inadequate community resources to provide other more appropriate accommodations." He calls for a clarification of the function of the nursing home and its position in the community's chain of services for the aged. Public welfare agencies all too frequently use nursing homes for the solution of social problems, rather than for the treatment of illness.

It is time to take a hard look at the status of the geriatric patient both in the hospital and in the nursing home, usually the only alternative shelter. Just what is the function of the nursing home, and what should it provide for him?

The Commission on Chronic Illness has estimated that there are in the United States 235,000 people in nursing and convalescent homes and homes for the aged. In addition, there are an estimated 45,000 long-term patients in general hospitals. The number of aged is increasing and will continue to do so. The increasing numbers of such patients in both types of institutions create unnecessary medical, administrative, and economic difficulties. Certainly their best interests are not served by keeping them in hospitals.

The philosophy of the care of older people who, by reason of circumstances, cannot remain in their own homes is fortunately undergoing radical change. This is due only in part to the increase in the numbers of such people. There is also increasing recognition by many engaged in institutional programs of the dignity of the individual regardless of age. Years do not necessarily deprive a person of his wits or his personality needs, even though circumstances may deny him the opportunity of living independently.

There are chronically ill patients who require regular and continuing services which can be provided only within a hospital. Others have permanent or static physical disabilities requiring medical and hospital services only occasionally. In an acute hospital situation, these chronically disabled persons often receive little attention, and as a result feel rejected and neglected. The function of the general hospital is to provide care for the actively ill. Pain and death are part of its daily routine. This is a poor environment for the chronically disabled. They have active and even intensified need for affection, emotional security, social contact, and spiritual development. Providing an opportunity for self-expression through creative activity, and a recognition of their personal dignity are equally important.

Most people readily concede that it is a great tragedy for the elderly to feel unwanted, useless, or helpless. The pattern of current living makes it increasingly difficult for older people to maintain their own homes. The trend to smaller houses and apartments and the scarcity of nurses and domestic help make home care difficult or impossible. Old age is a normal condition of life and should be a happy and satisfying period. It offers many opportunities for greater development and fulfillment. Unless some radical change in attitude brings this about, everyone will dread the approach of old age. Freedom from fear of the future is a desirable goal for society and may be thought of as the Fifth Freedom.

Yet this necessary change in philosophy is slow to produce results. The medical profession of Rhode Island has a stake in these goals. In Rhode Island, there are 161 licensed homes with a total of 2,229 beds. Licensing and regulation of nursing homes is under the jurisdiction of the director of the State Department of Social Welfare. The Rhode Island Medical Society's Committee on Social Welfare and the State Department of Social Welfare have worked together in keeping the standards of Rhode Island nursing homes tolerable. A recommendation is under consideration requiring the State Department of Social Welfare to employ a doctor of medi-

cine, on a full- or part-time basis, to supervise the medical provisions of the licensure regulations, with particular reference to individual medical care. Regulations requiring standard orders in nursing homes for all nurses, whether registered or practical, should be established and enforced. A pilot mental health program on a consultation basis has also been suggested. This would help the nursing home personnel to understand better the problems of the aged. A greater effort to tell the patient what is being done for him should be made. Periodic medical evaluations of each home should be considered and the results reported to the Committee on Social Welfare of the Rhode Island Medical Society.

The medical profession of Rhode Island is urged to participate vigorously in the development of this program.

THE POLITICS OF POWER IN A HOSPITAL

ONLY THE UNINITIATED believe that the organization chart shows where the power actually lies in a specific hospital. If you want to get a decision made in Hospital A you might go to one member of the board of trustees; in Hospital B you might go to a member of the medical staff; in Hospital C it might be the administrator who has the power, and in Hospital D it might be some other person.

Power in a hospital means the ability to make or influence important decisions.

Control of Strategic Resources

When one person provides a strategic amount of money for the hospital, that person tends to acquire power in the hospital.

The most important resources of a hospital is its medical staff, and the control of this resource by a single individual tends to give him important power.

Power Through Control of Communications

If the administrator is the sole channel of communication between the board of trustees on the one hand and the medical staff and hospital employees on the other, the administrator tends to have power.

The power derived from control of communication between the board and the medical staff is obvious, and it is for this reason that medical organizations insist on another channel going directly from the medical staff to the board.

Distortion of Organization

Where a single trustee (or a small group of trustees) becomes particularly active—either because the trustee needs something to do or because the hospital needs leadership—this trustee tends to usurp both the powers of the board of trustees and the executive responsibilities of the administrator.

Gerrymandering in a hospital is carving up responsibilities so as to take executive responsibility from the administrator.

The crystallizing of the hospital organization into a bureaucracy with an excessive amount of red tape is a favorite gambit to maintain the power in a status quo position.

Committee politics obviously play an important part in the power politics in the hospital.

The medical staff is effectively organized and usually has good channels of communication to the board of trustees. It consists of men who are generally respected in the community, and who know how to present their position. This group can be the main support of the administrator, and when the medical staff withdraws its support the administrator almost inevitably loses. It is paradoxical that the administrator must require the staff to comply with onerous and troublesome regulations regarding such matters as medical records and use of operating rooms. As one analyzes the various groups, it appears that the administrator of the hospital must depend on the medical staff for his strategic support, and when he loses this support he usually must resign.

There is a tendency to think that power comes as a result of fortuitous, external circumstances—for example, through the possession of wealth. But, observing the scene objectively, one is impressed by the number of situations where power is obtained because an individual has the ability to meet a need in leading the organization toward a desired goal. Usually two factors must be present; each amounts to little without the other, and yet neither can create the other.

First is the need within the organization for a certain type of leadership to achieve a desired goal. Second is a leader who can fulfill these needs. The special circumstances of World War II called Sir Winston Churchill to power, and he had the qualities and abilities to meet the needs. If the time had been one of peace and prosperity Sir Winston probably would not have become prime minister. In *The Admirable Crichton* the family butler changes roles and becomes the "governor" when the family is wrecked on a desert island; when the family is rescued and returns to civilization, he reverts to the butler's position.

Effective Leadership

Expertness or "expertise" as Robert Presthus* calls it is one type of leadership ability. Among a group in a lifeboat adrift at sea, the expert seaman

*Presthus, Robert V.: Authority in Organizations, Public Administration Review, 20:86 (Spring) 1960.

concluded on next page

tends to obtain power. In a scientific organization, the person with great scientific ability tends to have power.

But power must always be in terms of the needs of the organization. In the Happy Hollow Hospital there is a dishwasher, Mr. Pavoloski, who has an excellent voice of concert quality, while the administrator of the hospital couldn't carry a tune in a basket. In the operation of the hospital the administrator has the power, but when a group assembles to sing, Mr. Pavoloski has the power and the administrator becomes low man on the totem pole.

It should also be noted that success breeds power. If the hospital has become successful, the public is pleased, employee morale is good, the medical staff is satisfied, and the financing adequate—then the administrator tends to have power.

This success of the hospital is not necessarily the result of good administration. It may be in spite of the administrator just as much as because of the administrator, but whether or not he is responsible, success tends to give him power. It is equally true that if the hospital is not operating successfully the power of the administrator tends to be weakened, regardless of whether or not the responsibility for the failure was his.

MR. RICHARD T. VIGUERS, *Administrator*
Pratt Diagnostic Clinic,
New England Center Hospital, Boston.
From the MODERN HOSPITAL,
May, 1961

DID YOU KNOW?

- That the World Health Organization says malaria is humanity's single greatest cause of physical disability and the world's costliest disease.
- That malaria is a constant threat to more than one billion persons.
- That more than 300 million persons live in malarial areas in 73 countries and territories where malaria eradication programs are not yet in effect.
- That it is estimated that malaria is responsible for 10 to 15 per cent of infant mortality in malaria-ridden areas of the world.
- That in India, 50 million persons fall victim to malaria every year, causing an annual economic loss estimated by the World Health Organization at $500 million.

Nation Gets Younger, Older

The population of the United States is exploding, younging and aging — all at once.

An estimated 4,315,000 babies were born in the U.S. last year. By 1970, the number of young people under 20 years of age will reach 87,000,000 according to population experts.

People 65 years or older will number an estimated 20,000,000 in 1970. By then, half of the entire population of the country will be under 20 or over 65.

AS CLEAN
AS MODERN
DAIRY SCIENCE
CAN MAKE IT...





The A. B. Munroe Dairy Laboratory, where milk is subjected to constant testing, using the most modern methods of milk analysis.

Through every step in processing, from the immaculate receiving room to pasteurizing and homogenizing, on through bottling and refrigeration, the A. B. Munroe Dairy observes the strictest standards of dairy hygiene. The spotless surroundings and rigid quality control are so designed that all A. B. Munroe Dairy products that reach your table are as fresh, wholesome and pure as modern science can make them.



A. B. MUNROE DAIRY, INC.
151 Brow Street, East Providence, Rhode Island

Call GE 8-4450
for Home Delivery

HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY
Report of Meeting January 24, 1962

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library, in Providence, on Wednesday, January 24, 1962. The meeting was called to order by the president, Doctor Samuel Adelson, of Newport, at 8:05 P.M. The following delegates were in attendance:

Bristol County: Robert W. Drew, M.D. Kent County: Peter C. Erinakes, M.D.; Edmund T. Hackman, M.D., and John M. Vesey, M.D. Newport County: Philomen Ciarla, M.D., and Charles Dotterer, M.D. Pawtucket District: Edward Butler, M.D.; Walter Dufresne, M.D.; Francis Hanley, M.D.; Robert C. Hayes, M.D., and Earl F. Kelly, M.D. Washington County: Freeman B. Agnelli, M.D., and James A. McGrath, M.D. Woonsocket District: No delegates present. Officers of the RIMS (other than delegates): Samuel Adelson, M.D.; Arthur E. Hardy, M.D.; Michael DiMaio, M.D., and J. Murray Beardsley, M.D. Delegate to A.M.A.: Charles J. Ashworth, M.D.* State Health Dept. Director: Joseph E. Cannon, M.D.* Immediate Past President of RIMS: Earl J. Mara, M.D. Providence Medical Association: Robert R. Baldridge, M.D.; John T. Barrett, M.D.; Irving A. Beck, M.D.; J. Robert Bowen, M.D.; Bertram H. Buxton, Jr., M.D.; Wilfred I. Carney, M.D.; Joseph E. Caruolo, M.D.; Francis H. Chafee, M.D.; Henry B. Fletcher, M.D.; Warren Francis, M.D.; Frank D. Fratantuono, M.D.; J. Merrill Gibson, M.D.; J. Merrill Gibson, Jr., M.D.; John F. W. Gilman, M.D.; Seebert J. Goldowsky, M.D.; Stanley Grzebien, M.D.; John C. Ham, M.D.; Waldo O. Hoey, M.D.; Walter S. Jones, M.D.; Robert V. Lewis, M.D.; Frank MacCardell, M.D.; William J. MacDonald, M.D.; Gustavo A. Motta, M.D.; William S. Nerone, M.D.; Francis W. Nevitt, M.D.; Arnold Porter, M.D.; William A. Reid, M.D.; Ralph D. Richardson, M.D.; Jack Savran, M.D.; Carl S. Sawyer, M.D.; Stanley D. Simon, M.D.; John Turner II, M.D., and Elihu S. Wing, Jr., M.D.

Also present at the meeting were: Doctor Thomas Perry, chairman of the Sesquicentennial Committee; Doctor Jesse P. Eddy III, chairman of the Committee on Scientific Work and Annual Meeting; John E. Farrell, executive secretary, and several physicians, nonmembers of the House.

*Without the power of vote.

MINUTES OF PREVIOUS MEETING

Doctor Adelson noted that the minutes of the September, 1961, meeting of the House of Delegates had been distributed to the members, and had been published in the RHODE ISLAND MEDICAL JOURNAL. A motion was made, seconded and passed that the minutes as submitted be approved and placed on file.

REPORT OF THE PRESIDENT

Doctor Adelson commented in detail on some of the matters presented in his report to the delegates as published in the handbook distributed prior to the meeting.

A motion was made, seconded and passed that the report of the president be received and placed on file.

REPORT OF THE SECRETARY

Doctor Michael DiMaio, secretary, read his report as published in the handbook.

A motion was made that the report of the secretary be received and placed on file. The motion was seconded and adopted.

REPORT OF THE SESQUICENTENNIAL COMMITTEE

Doctor Thomas Perry, chairman of the Sesquicentennial Committee, gave an oral report on the activities of the committee in planning the Exposition of Health Progress. He stressed the importance of participation in the Health Fair by the members of the Society.

REPORT OF THE TREASURER

Doctor J. Murray Beardsley, treasurer, noted that his annual report of the financial record of the Society for 1961, and including the investment program, was included in the handbook, and that it had been approved by the Council.

A motion was made, seconded and passed that the annual report of the treasurer be received, approved and placed on file.

continued on next page

Nominees for Board of Directors of Physicians Service

The president noted that the House was called upon to nominate four physicians for three-year terms on the Board of Directors of Physicians Service, said nominees to be submitted to the Corporation of Physicians Service at its annual meeting.

On individual nominations the following physicians were placed in nomination, and nominations were closed by vote of the House: Charles J. Ashworth, M.D.; Seebert J. Goldowsky, M.D.; William A. Reid, M.D.; Francis B. Sargent, M.D.; J. Merrill Gibson, M.D., and Frank D. Fratantuono, M.D.

The Chair ruled that with the approval of the House the four nominees receiving the largest number of votes would be declared the choices of the House. The decision was approved. Doctors John Gilman and Stanley Grzebien were named as tellers.

On a written ballot the following were elected as the nominees: Charles J. Ashworth, M.D.; Seebert J. Goldowsky, M.D.; William A. Reid, M.D., and Francis B. Sargent, M.D.

Tribute to Doctor H. P. Gongaware

Doctor F. B. Agnelli, delegate from Westerly, reported that Doctor H. P. Gongaware, a member of the House from Westerly, had died unexpectedly this day, and he offered the following resolution:

WHEREAS, Hartford P. Gongaware, M.D., a member of this House of Delegates from Washington County, met an untimely death this day, and

WHEREAS, he was a Delegate for the past eight years from Washington County, a past president of the Washington County Medical Society and considered the dean of his colleagues in Westerly, esteemed throughout the state by his colleagues and patients,

THEREFORE BE IT RESOLVED that this House of Delegates of the Rhode Island Medical Society express its deep sympathy to the family of Doctor Gongaware in their great loss.

Honorary Membership in the Society

The president called to the attention of the delegates the action of the Council of the Society in voting to recommend to the membership at the annual meeting the election of three Rhode Islanders to honorary membership, as noted in the report in the handbook.

Report on Glaucoma Detection Program

The president noted that a report from the Rhode Island Ophthalmological Society in answer to the request of the House for action on a proposed glaucoma detection program was included in the handbook.

A motion was made, seconded and passed that the report as submitted from the Rhode Island Ophthalmological Society be received, approved and placed on file.

Report of Cancer Committee

A report from the Cancer Committee was included in the handbook of the Delegates, and the president asked for action on it.

A motion was made, seconded and passed that the report of the Cancer Committee, as submitted, be approved and placed on file.

Report of the Disaster Committee

Doctor Francis Hanley submitted the report of the Disaster Committee, copy of which was included in the delegate's handbook.

A motion was made, seconded and passed that the report be received and placed on file.

Medical Defense and Grievance Committee

Doctor Francis B. Sargent, chairman of the Committee on Medical Defense and Grievance, gave an oral report on the recent activities of that committee. The report was approved.

Medical Economics Committee

Doctor Stanley D. Simon reviewed the report of the Committee on Medical Economics of which he is the chairman. Copy of the committee report was included in the delegate's handbook. There was general discussion by the delegates of some of the issues raised in the report.

A motion was made, seconded and passed that the report of the Committee on Medical Economics be approved and placed on file.

Nominees to the Blue Cross Board

The president noted that the Society is asked annually to name two nominees for the Board of Directors of the Hospital Service Corporation of Rhode Island (Blue Cross).

A motion was made, seconded and passed that Doctors Arnold Porter and William A. Reid be the Society's nominees to serve on the Board of Directors of Blue Cross.

Report on Physicians Service

Doctor Charles J. Ashworth, president of Physicians Service, noted that reports of the September, October, and December meetings of the Board of Directors had been included in the delegate's handbook. He briefly discussed some of the recent activities of Physicians Service, and he urged that members of the Society strongly oppose state legislation that would remove a medical majority from the Board of Directors of the plan.

There was general discussion by members of the House on various phases of Physicians Service, and in particular regarding the claim form and the reporting thereon of the physician's usual fee. The

continued on page 164



oday's little "limey" needs a half barrel of orange juice

, to be exact, a total of 2,106 ounces
is first two years. And how much
need during his first twenty years
ld have to be measured by the truck-
, because the need for the nutrients
ained in Florida orange juice con-
es throughout life.

ow our little "limey" or any of your
r patients obtain the vitamins and
ients found in citrus fruits is im-
ant to them and to you. There are
any wrong ways, so many substi-
s and imitations for the real thing.

For a way that combines real nutrition with real pleasure, there's nothing better than the oranges and grapefruit ripened under Florida's own sunshine. Somehow, nothing can surpass the result of the combination of sun, air, temperature, and soil found in Florida.

It's good nutrition to encourage people to drink orange juice. It's even more judicious to encourage them to drink the juices and eat the fruits watched over by the Florida Citrus Commission. These men set the world's highest standards of quality in fresh, frozen, canned, or cartoned citrus fruits and juices.

When you suggest to your patients that they have a big glass of orange juice for breakfast, or for a snack, or when they want to raid the refrigerator, the deliciousness of Florida orange juice will give you assurance that they'll *want* to carry out your recommendation. You'll be helping them to the finest drink there is—by the glassful or the barrel.

© Florida Citrus Commission, Lakeland, Florida

HOUSE OF DELEGATES

continued from page 162

suggestion was made that the board of directors give this item particular attention at its next meeting.

Committee on Scientific Work and Annual Meeting

Doctor Jesse P. Eddy III, chairman of the Committee on Scientific Work and Annual Meeting, reported on plans for the Society's scientific assembly to be held at the Brown University Gymnasium on May 8 and 9.

Public Information Committee

Doctor William A. Reid, chairman of the Public Information Committee, reported on the organization of the committee, and its current activities. He related that district medical society liaison committees are currently staging meetings with state legislators to discuss legislation affecting medicine and public health. There was discussion by the delegates.

A motion was made, seconded and passed that the report of the chairman be approved.

Report of State Director of Health

Doctor Joseph E. Cannon, state director of health, and ex officio a member of the House, spoke briefly on the need for close working relations between his department and the state medical society, and he expressed his appreciation with the appointment of a new Public Health Committee with which he may work directly. He reported that legislation was being prepared relating to the medical licensing act which would be submitted to the Society.

Miscellaneous Business

The suggestion that a study be made of a method of compensating physicians for in-hospital welfare patients for medical care was referred to the Committee on Social Welfare.

DOCTORS' OFFICE-SUITE FOR RENT

Medical Building

154 Waterman St., corner Cooke St.
Providence

Air Conditioning, Heating and Parking

IMMEDIATE OCCUPANCY

HOWARD REALTY COMPANY
10 Dorrance Street GA 1-5336

The suggestion that the president call a special meeting of the House of Delegates if legislation now before the General Assembly affecting Physicians Service is reported favorably by assembly committees, was referred to the president.

Adjournment

The House adjourned at 10:25 P.M.

Respectfully submitted,

MICHAEL DIMAIO, M.D., *Secretary*

REPORT OF THE PRESIDENT

The past four-month period since the previous meeting of the House of Delegates has been a trying one for your officers and we have faced several serious issues.

There is little need for me to review the implications of the so-called public hearings of the state director of business regulation, relative to the Physicians Service program, the widely publicized allegations of Mr. Lawrence Spitz, spokesman for the state AFL-CIO, and more recently the legislative proposals to take over the directorship of the Rhode Island Medical Society Physicians Service.

We believe we have met these issues squarely, and in an honest and dignified manner. Certainly the profession and the Society's views were excellently presented in the series of articles prepared for the Providence *Journal-Bulletin*, and we hope they gave the public a better understanding of the scope and purpose of the insurance plans.

I have met with the governor, with members of the General Assembly, and with the editors of the *Journal-Bulletin* to make known the Society's positions on any and all issues raised. It is not easy to determine the basis for the criticisms of the medical profession at this time. We do not maintain we are entirely without fault, yet we most certainly did not warrant the criticism that stemmed from undocumented allegations given unusual prominence by our largest daily newspaper.

Regardless of everything, it is very apparent that every member of the Society has the obligation to take a keener interest in the work of his medical organization, to support the Council, this House of Delegates, and the officers you have chosen to maintain the dignity and high standards that mark our profession.

The Public Information Committee that you established at the September meeting has been actively at work, and it has the added support of similar committees in the local district societies. The task at hand is not one for a public relations expert to solve by the magic of words; it is a task for every physician.

On the national level we face another controversial issue that is clouded with much misunderstanding. The King-Anderson bill to legislate medical

care for the aged through the social security system is not the answer to our problem. We here in Rhode Island have shown how effective the voluntary insurance plan can be, and we have taken persons of all ages above 65 as members. Under our "A" plan the over age 65 subscriber is today receiving far greater benefits at lower cost than is proposed by the national plans. You have an obligation to be informed on the Congressional activities as publicized in our Journal and the Journal of the American Medical Association. You have an equal obligation to write to our Rhode Island members in Congress and make known to them your views on this and other vital legislative proposals.

This is our Sesquicentennial Year. You have responded well to the special assessment to make the Health Exposition a public demonstration by the Society of its interest in the health and welfare of everyone. You will be called upon in April to staff the displays at the Health Fair, and to explain medical and health matters to the visitors. The opportunity will be a wonderful one for every member of the Society to participate in a public relations effort without parallel in the long history of the Society.

Our annual scientific meeting will be held in the Brown University gymnasium. The Committee on Scientific Work has done a notable job in planning this session to be one of the most elaborate we have ever staged. You should show your appreciation by attendance at the two days of lectures. Tonight you will find in your handbook the notation that the Council recommends the awarding of honorary memberships on the occasion of our 150th celebration. I sincerely hope this proposal has the full support of the membership.

In the past four months I have attended most of the meetings held by the various committees, and I assure you that the work of these units of your Society is tremendous. In addition, the Council has held two long meetings at which it has carried out the ever increasing activities of the profession in serving the public and its own members.

SAMUEL ADELSON, M.D., *President*

REPORT OF THE SECRETARY

The Council has held two meetings since the September meeting of the House of Delegates. Actions taken at these meetings included the following:

1. The Council heard a report on the plans of Brown University for medical education, and it expressed both its approval of the development of a medical school at Brown University and its offer of co-operation in making available the facilities of the Society in the furtherance of the program.
2. The problem of licensure applying to clinical laboratories in the state was reviewed with representatives of the Rhode Island Society of Pathologists.
3. Paid advertisements in all the daily newspapers in Rhode Island were authorized to publicize television programs sponsored by the Woman's Auxiliary.
4. The allegations of the state AFL-CIO were considered, and the president was authorized to make known the Society's willingness to have representatives of the Rhode Island Bar Association sit with the Grievance Committee for hearings on the alleged abuses.
5. The Council approved of the Society being a co-operating organization with the Rhode Island Heart Association for the Fourth Cardiovascular Symposium for Physicians to be held March 21, 1962.
6. A report from special delegates to an A.M.A. regional meeting on Medical Education and Hospitals was received, reviewed and placed on file.
7. Approval was given to the request of the Cancer Committee to make a mailing to the membership.
8. The Council approved of a demonstration project of the Division of Tuberculosis Control of the Rhode Island Department of Health, jointly with the U.S. Public Health Service, whereby free distribution of necessary drugs would be carried out as a public health measure for patients under medical supervision and requiring the use of long-term medication for tuberculosis.
9. The annual report of the treasurer was received, reviewed and approved.
10. The president was authorized to appoint a Public Health Committee consisting of the chairmen of the committees on cancer, child-school health, diabetes, disaster, federal medical services, industrial health, maternal health, grievance, mental health, perinatal mortality, and public laws, said committee to be available to discuss public health problems with federal, state and local health agencies.
11. The following were named official delegates of the Society to national and other meetings: Doctor Earl F. Kelly to the 58th Annual Congress on Medical Education and Licensure; Doctor Harold Williams to the A.M.A. Conference on Mental Health; Doctor Francis B. Sargent to the International Medical-Legal Conference.
12. The president was authorized to name two delegates to attend an A.M.A. sponsored National Legislative Conference in Chicago.
13. The president was authorized to notify the Rhode Island Congressional delegation of the Society's objections to enactment of the King-Anderson bill now before the Congress.

continued on next page

Will sublet two connecting rooms in modern air-conditioned professional building on Waterman Street in Providence. Separate entrance, parking and janitorial service. All replies confidential.

Telephone DE-1-5024

14. Doctor Francis B. Sargent, chairman of the Grievance Committee, was authorized to answer an inquiry from the Providence *Journal-Bulletin* regarding the work of the Society's grievance committee during the past three years.

MICHAEL DIMAIO, M.D., *Secretary*

ANNUAL REPORT OF THE TREASURER

A complete financial statement of the Society's general operating account, including the medical journal publication, as well as the investment portfolio established with the Trust Department of the Industrial National Bank in Providence has been reviewed and approved by the Council. All receipts were traced into the bank and canceled checks were examined and checked to disbursement records. Totals of duplicate deposit slips were verified and checked to ledger accounts recording the various classification of receipts. All ledger account additions were verified.

The General Account, or operating fund, for the Society's activities started the year with a cash balance of $7,546.48. Total receipts from all sources, mainly dues, provided $69,056.53, and total expenses were $61,785.21, resulting in a cash balance as of the first of the year in the amount of $14,817.80. The balance is higher than a year ago due in large measure to the fact that in 1960 a sizable expenditure was met in repair work at the Library Building.

The Sesquicentennial Account, established by special action of the House of Delegates during the year, has produced a total of $14,861 to date, and the expenditures against this account have been $2,927.78, leaving a cash balance as of January 1 of $11,933.22.

The Investment Accounts netted us less than fifty dollars more than the 1960 income, the total for 1961 being $3,106.52 as against $3,062.03 the previous year. The market value of the investments rose, however, from a gross total of $85,198 at the end of 1960 to $98,819 in 1961. In the opinion of the Trust Department of the bank, the quality of these securities seems suitable for their retention at this time, and no changes in investments are recommended.

The Rhode Island Medical Journal encountered a heavy loss in 1961 due to the drop in volume of pharmaceutical advertising. The loss paralleled a national situation which saw all medical journal advertising off by 40 per cent by the end of the year. Fortunately the *Journal* had an operating surplus with which to meet this emergency, but unless there is a reversal in the advertising situation in the coming months the Society will have to consider a larger subsidy to enable the magazine to continue its current size and content.

The *Journal* cannot close its books until late in January, as the December issue is not distributed until the end of the year, and payments for advertising and printing are not made until late in January. However, by the end of 1961, with the December loss yet to be figured, the *Journal* had sustained a loss of $2,766.04 for the year.

Receipts, through December, were $16,127.40 against operating expenses, mainly printing of the *Journal*, of $18,893.44. The *Journal* started the year with cash reserves in the amount of $8,372.42, and as of December 31, 1961 had a cash balance of $5,606.38.

Respectfully submitted,

J. MURRAY BEARDSLEY, M.D., *Treasurer*

Rhode Island Medical Society
*Financial Report, 1961**

Summary

Cash Balance, General Account, Industrial Nat'l Bank, Jan. 1, 1961		$ 7,546.48
Receipts, 1961 (Exhibit A)		83,917.53
General Funds:	$69,056.53	
Sesquicentennial Assessment:	14,861.00	
Total		$ 91,464.01
* * *		
Expenses, 1961 (Exhibit B)		$ 64,712.99
General Account:	$61,785.21	
Sesquicentennial:	2,927.78	
* * *		
Cash Balance, Industrial Nat'l Bank, Jan. 1, 1962		$ 26,751.02
General Account:	$14,817.80	
Sesquicentennial:	11,933.22	
Investments (Exhibit C) (Market Values)		$ 98,807.00
Total cash and invested assets		$125,558.02

*(Exclusive of Journal Account.)

J. MURRAY BEARDSLEY, M.D., *Treasurer*

GLAUCOMA DETECTION PROGRAM

To the House of Delegates:

At a meeting of the Rhode Island Ophthalmological Society, held on October 26, 1961, the communication to the Rhode Island Medical Society from Doctor Thomas H. Murphy, assistant director of Health, regarding the organization of a Glaucoma Detection Program in Rhode Island and referred to the Rhode Island Ophthalmological Society by the Rhode Island Medical Society, was considered.

This proposal was originally made to the Rhode Island Ophthalmological Society two years ago and

Doctor Murphy attended one of the society meetings to present his ideas regarding this program and a general discussion of Glaucoma Detection Programs was held at that time. Subsequently, it was voted not to take part in the Glaucoma Detection Program for the following reasons:

1. Glaucoma detection is being carried out daily in the eye clinics and ophthalmological offices of Rhode Island.
2. A glaucoma detection program such as was considered would actually reach a minute portion of the state's population and would not result in the recognition of an appreciable number of new cases of glaucoma.
3. Glaucoma detection programs are valuable in publicizing glaucoma and the necessity for its early detection. The Rhode Island Ophthalmological Society felt that excellent publicity is currently being given glaucoma through various other media.
4. Glaucoma detection surveys have been proven useful in determining the incidence of undetected glaucoma in the general population. Numerous well-controlled studies have been carried out and the results have been remarkably uniform.

At the meeting on October 26, 1961, the Glaucoma Detection Program was reconsidered and the members of the Rhode Island Ophthalmological Society again declined to participate in this program.

It was the consensus of the members that it would be of considerably more value for the Rhode Island Ophthalmological Society to participate as a public service in a program of preschool vision testing. This was recommended for the following reasons:

1. Little publicity has been given to the problem of undeveloped vision. It is conservatively estimated that each year 100,000 American children pass the age at which effective remedial measures may be instituted. School vision testing comes too late for the institution of effective treatment.
2. There have been very few controlled studies and surveys of large segments of the population in the preschool vision age group.
3. Preschool vision testing may be actually carried out by trained lay personnel and thus, a program on a larger scale and of a continuing nature, could well be instituted.

Two years ago, Doctor Murphy was advised regarding the desire of the Rhode Island Ophthalmological Society to sponsor a program of preschool vision testing rather than the inauguration of a glaucoma detection program. At the present

continued on next page

One Caution When You Buy Mink...



Consult a reliable furrier who is interested in protecting your interests, with honest value and guaranteed quality. Come to Harris, and buy with confidence!

WILLIAM H. Harris

New England's Largest Exclusive Furrier
400 Westminster Street
Our 2nd Half-Century of Fine Fur Tradition

LIFE INSURANCE or DEATH INSURANCE?

SOME Medical men need DEATH Insurance ONLY.

Others need accumulating, guaranteed dollar values to meet their LIVING needs in the future — DEPRESSION — EMERGENCY — RETIREMENT, etc.

In any event, our new "CHEAPER-THAN-TERM" DEATH INSURANCE is the first step in the right direction!

Don't make any important changes in your Life Insurance or Estate plans without investigating "CHEAPER-THAN-TERM"!

For further information about this sensational new development in DEATH INSURANCE, write or phone:

ROLAND A. DEROSIER
32 Custom House Street
Providence 3, Rhode Island
GA 1-1391

time steps are being taken to sponsor a Rhode Island Chapter of the National Society for the Prevention of Blindness in Rhode Island. It is hoped that by this means, we will institute an effective program of preschool vision testing.

Respectfully submitted,

JOSEPH L. DOWLING, JR., M.D., *Secretary*

CANCER COMMITTEE

Wednesday, March 28, has been designated as Cancer Day by the Cancer Committee of your State Medical Society. The reason for advancing this date to March, rather than maintaining the month of April for this meeting, is to avoid conflicts with other medical meetings.

The meeting will be held in the Medical Society Library at 2:00 P.M. and will consist of a panel discussion of *Carcinoma of the Colon and Rectum*, with Doctors Michael Deddish, Gordon Zubrod, and Alexander Margulis functioning as the panelists. A moderator for this panel has not yet been chosen.

The reason for suggesting *Carcinoma of the Colon and Rectum* for this year's presentation is because this is the main organ of emphasis stressed by the American Cancer Society at the present time.

We trust that this will be a well-attended meeting, and we are certain that the caliber of our panelists is outstanding.

Respectfully submitted,

HENRY C. MCDUFF, JR., M.D., *Chairman*

DISASTER COMMITTEE

The Disaster Committee is pleased to report activity during the past six months in an attempt to keep up with Civil Defense activities locally and nationally and acquaint the committee members and the Society with American Medical Association plans.

June 24, 1961—Attendance at the Ninth Annual National Conference on Disaster Medical Care presented by U. S. Air Force Medical Service at A.M.A. Annual Meeting in New York City. This conference emphasized that civilian training, preparation and knowledge is an instrument of national power.

Meetings of the committee were held in September, October, and November to discuss with each other the local needs and the part the Medical Society will play in event of national disaster. General McGreevey addressed the October meeting and presented the elements of the Rhode Island State Plan to the committee.

November 4-5, 1961—Attendance at the County Medical Societies Conference on Disaster Medical Care in Chicago. Here the emphasis was placed on the need for a positive civilian defense program in each state. Stress was put on the need for a full-time medical director in each state. From this it was believed that something tangible in the medical aspects of Civilian Defense would result.

Also the need for implementation of the Self-Help Program in each state and county medical society must be developed. This is a plan for the instruction of at least one member of every family in the country in the fundamentals of survival in a nuclear blast.

The committee is pleased to report the appointment of Hilary J. Connor, M.D., as a medical director in the Rhode Island State Civil Defense. His duties will be to organize a positive Civilian Defense Medical Program.

Respectfully submitted,

FRANCIS E. HANLEY, M.D., *Chairman*

COMMITTEE ON MEDICAL ECONOMICS

During the year 1961, the Committee on Medical Economics met many times with the officials of the Rhode Island Hospital Trust Company and the Industrial National Bank, as well as representatives of Edwards & Angell, legal counsel for the Society, relative to an investment program for doctors.

The investment program initiated by your committee and developed by the two largest banks of Rhode Island was finally approved by the Federal Reserve Bank and is now growing. The simplicity of the plan has attracted national attention, and articles concerning it have appeared in FORTUNE magazine and the AMERICAN BANKER, as well as the local press. Your committee recommends that every member avail himself of this plan which is based on the principle of "dollar averaging," and in addition is automatic. We hope that the young doctor for whom this investment program was especially designed will acquaint himself with this service sponsored by your committee.

The health and accident disability insurance plan developed by the Providence Medical Association and available also to members of the Rhode Island

J. E. BRENNAN & COMPANY
Leo C. Clark, Jr., B.S., Reg. Pharm.
Apothecaries
Two Convenient Locations
5 North Union Street — Pawtucket, R. I.
140 Central Avenue — Seekonk, Mass.
7 Registered Pharmacists
Pharmacy License #226

Medical Society, was changed during the past year to provide that the extended benefits phase of the plan be handled by the Continental Casualty Company instead of the Banker's Life, as formerly. The program continues to offer physicians one of the best group programs of insurance available to any medical society organization.

On October 27, 1961, a meeting was held with Mr. Harold Arcaro, director of the state Department of Business Regulation, and Mr. Timothy Carmody, chief insurance examiner of the state. This was an "off the record" discussion on the public hearings on the Blue Cross and Physicians Service request for rate changes. Doctor Samuel Adelson, who was present at this meeting, summarized the position of the Society.

On November 14, 1961, officials of the AFL-CIO were invited to meet with your committee to discuss mutual problems, as we had done previously on March 24, 1960. Present were Thomas Policastro, president; Edwin Brown, secretary-treasurer; Lawrence N. Spitz; George Butsika, and John N. Gould.

In addition to the Committee on Medical Economics, Doctor Francis B. Sargent, chairman of the Medical Defense and Grievance Committee; Doctor S. J. Goldowsky, editor of the RHODE ISLAND MEDICAL JOURNAL; Doctor Arnold Porter, secretary of the Board of Physicians Service; Doctor Arthur E. Hardy, president-elect of the Society, and Doctor Frank Fratantuono, president of the Providence Medical Association, were present.

Your committee explained its functions and reminded the members of the AFL-CIO that we had met previously and that we were to be invited to explore our mutual problems, but that no such invitation to meet with their board was ever issued. We expressed our regret that they had taken the initiative to publicize this meeting before we had even met.

The two cases which had been given wide publicity by Mr. Spitz at the rate hearings before Mr. Arcaro were discussed, and it was apparent that the members of the AFL-CIO had not contacted either of the physicians concerned before they made their allegations. No attempt was made to discuss the so-called 180 cases of alleged abuse, but ground rules were presented by the labor representatives before they would present the cases for investigation. The minutes of the meeting and their request was then turned over to the Council for their action. I am sure you are all well acquainted with the proposal for investigation as presented by Doctor Adelson, a copy of which was included in the RHODE ISLAND MEDICAL JOURNAL.

We wish to repeat that your committee had held an excellent meeting in 1960 with Mr. Policastro and Mr. Brown, and trust that the representatives of labor will realize that this Society is anxious to meet with any group with the aim of serving the people of Rhode Island.

At the present time, liaison between this committee and representatives of the insurance industry are under way to help solve mutual problems.

A Group Life Insurance proposal, submitted by the Derosier Agency, is under study by your committee.

Response to request for changes in the Physicians Service Fee Schedule indicates that many physicians are not happy with the present schedule. The major complaints fall under the following categories:

1. Assistants' fees were inadequate and should be raised.
2. Provisions for medical emergency payments which require prolonged and immediate attention.
3. Provisions for medical care post-operatively and for consultation.
4. For medical patients in hospital — first visit $10 and then $5 per day regardless of income levels. This seemed to be the most popular request.
5. Payment for EKG in office.
6. Change in fee schedule for certain procedures. The different surgical specialties listed many changes that they felt were long overdue. A few examples: (a) Tonsillectomies—change from $25 to $50; (b) Thoracotomies—from $100 to $175, and (c) Scalenus Node Biopsy —from $25 to $50.
7. Complaints from surgeons and anesthetists concerning income limits were many. The principal complaint of the anesthesiologist was that he had little opportunity to obtain the income status of the patient, and to do so placed an unfair financial burden on his specialty. For this reason most of the anesthesiologists have given up trying to ascertain income groups and they send their regular bills for services to all patients.

Regarding the question of surgical consultations requiring repeated surgical interventions, some method should be worked out so that the attending surgeon may be recompensed for each operation. It is a fact that if the case were turned over to another surgeon, the fee would be paid for each surgical intervention.

Respectfully submitted,

STANLEY D. SIMON, M.D., *Chairman*

Patronize Journal Advertisers

RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE

Report of the Thirteenth Annual Meeting of the Corporation, January 29, 1962

THE THIRTEENTH ANNUAL MEETING of the Corporation of the Rhode Island Medical Society Physicians Service was held in the Garden Room of the Providence Sheraton-Biltmore Hotel, in Providence, Rhode Island, on Monday, January 29, 1962. At the conclusion of the dinner the Corporation was called to order for its business meeting by the President, Doctor Charles J. Ashworth, at 8:05 P.M. The following members of the Corporation were in attendance:

Samuel Adelson, M.D.
Charles J. Ashworth, M.D.
Robert Baldridge, M.D.
John T. Barrett, M.D.
J. Murray Beardsley, M.D.
Joseph A. Bliss, M.D.
Chelcie C. Bosland, Ph.D.
J. Robert Bowen, M.D.
Bertram H. Buxton, Jr., M.D.
Wilfred I. Carney, M.D.
Mr. J. Austin Carroll
Joseph Caruolo, M.D.
Mr. George W. Chaplin
Philomen P. Ciarla, M.D.
Michael DiMaio, M.D.
Mr. James R. Donnelly
Robert W. Drew, M.D.
Walter Dufresne, M.D.
Frederick C. Eckel, M.D.
Peter Erinakes, M.D.
Mr. Emil E. Fachon
Charles L. Farrell, M.D.
William J. H. Fischer, Jr., M.D.
Henry B. Fletcher, M.D.
Henri Gauthier, M.D.
J. Merrill Gibson, M.D.
J. Merrill Gibson, Jr., M.D.
John F. W. Gilman, M.D.
Seebert J. Goldowsky, M.D.
Stanley Grzebien, M.D.
Edmund T. Hackman, M.D.
Mr. John J. Hall
John C. Ham, M.D.
Francis Hanley, M.D.
Robert C. Hayes, M.D.
Waldo O. Hoey, M.D.
Robert V. Lewis, M.D.
Frank J. Logler, M.D.
William MacDonald, M.D.
Earl J. Mara, M.D.
Frank I. Matteo, M.D.
James A. McGrath, M.D.
Edward Medoff, M.D.
Gustavo Motta, M.D.
William S. Nerone, M.D.
Francis W. Nevitt, M.D.
Arnold Porter, M.D.
William A. Reid, M.D.
Ralph Richardson, M.D.
Francis B. Sargent, M.D.
Carl S. Sawyer, M.D.
Stanley D. Simon, M.D.
Robert D. Stuart
John Turner, M.D.
John M. Vesey, M.D.
Elihu Wing, Jr., M.D.

Members absent were:

Rocco Abbate, M.D.
Freeman B. Agnelli, M.D.
Irving A. Beck, M.D.
Edward Butler, M.D.
Joseph E. Cannon, M.D.
Francis H. Chafee, M.D.
Morgan Cutts, M.D.
Charles Dotterer, M.D.
Mr. Walter Farrell
Warren W. Francis, M.D.
Frank D. Fratantuono, M.D.
Mr. John J. Halloran
Arthur E. Hardy, M.D.
Walter S. Jones, M.D.
Earl F. Kelly, M.D.
Frank MacCardell, M.D.
Mr. Felix Mirando
Mr. George Ramsbottom
Jack Savran, M.D.
Mr. John Shepard II
Saul Wittes, M.D.
George L. Young, M.D.

Also present were the following: John E. Farrell, SC.D., executive secretary; Arthur H. Hanley, acting executive director; Edgar H. Clapp, associate executive director; William E. McCabe, legal counsel; J. Lewis Eddy, director of claims; George Peterson, assistant claims director; Frank Addae, director of public relations.

Annual Report of the Secretary

Doctor Arnold Porter, secretary, noted that his annual report had been submitted to the members of the Corporation in advance of the meeting, and therefore it would not be read unless there was a request for a reading.

Action: A motion was made, seconded and passed that the annual report of the secretary, as submitted to the Corporation, be approved and placed on file as an official part of the records of the meeting.

Annual Report of the Treasurer

Mr. James R. Donnelly, treasurer, read the following annual report for the year 1961, and submitted statistical information which had been sent to the members of the Corporation with the notice of the meeting:

"Gross income reached a new peak of $9,187,336.48 which was an increase of $878,061.92 over 1960. This gain in gross income was due in part to the 7,677 new subscribers last year and to the changeover of 14,000 A subscribers to the more expensive B plan. We now have 148,000 subscribers enrolled under the B plan.

"Surgical-Medical claims paid for subscribers rose to $8,444,610.21, an increase of $486,404.09 over the previous year.

"Operating expenses were up $71,776.00 to $531,938.87 or 5.8% of income. Our work load continued to increase, and so it follows that our cost of operation must rise also.

"After suffering losses for the two previous years, $109,000.00 in 1960 and $218,000.00 in 1959 for a total of $327,000.00, we are happy to report that last year we were in the black again with a net profit of $210,788.40.

"Statutory and Contingency Reserves totaled $1,601,796.42, sufficient for 2.91 months of claims. National Blue Shield requirement is an amount equal to 3 months' claims.

"After having losses for the first six months of the year, a steady improvement was noted in the last half of the year, when utilization dropped off.

It appears that the present schedule of rates, in effect throughout the year, was right for last year and definitely helped to improve our financial position. Of course we know that 1962 will bring new problems, but we feel confident that with the co-operation of the doctors, the subscribers and the state authorities, we can continue on a sound basis."

Action: A motion was made, seconded, and adopted that the annual report of the treasurer, as submitted, be approved and placed on file.

Report of the President

Doctor Charles J. Ashworth, president, read his annual report.

Action: A motion was made, seconded, and adopted that the annual report of the president, as submitted, be approved and placed on file as an official part of this meeting.

Election of Directors

The president noted that the Board of Directors had amended the bylaws at a recent meeting to provide, among other changes, that the non-physician directors should be elected by the Corporation at its annual meeting, starting with the 1962 Annual Meeting.

A motion was made, seconded, and passed that the Corporation express its approval of the amendments to the bylaws made by the Board of Directors.

* * *

On separate motions from the floor the following nominations were made and the directors elected for the terms indicated:

John J. Hall and Robert D. Stuart to serve three-year terms each, until the annual meeting in 1965.

George W. Chaplin and James R. Donnelly to serve two-year terms each, until the annual meeting in 1964.

Chelcie C. Bosland, PH.D., and J. Austin Carroll to serve one-year terms each, until the annual meeting in 1963.

* * *

The president reported that the House of Delegates of the Rhode Island Medical Society had nominated for three-year terms, to serve until the annual meeting in 1965, the following: Charles J. Ashworth, M.D.; Seebert J. Goldowsky, M.D.; William A. Reid, M.D.; and Francis B. Sargent, M.D.

Action: A motion was made, seconded, and passed that the nominees of the House of Delegates of the Rhode Island Medical Society be elected to serve as directors.

Miscellaneous Business

Possible Bylaw Change: Doctors Adelson and Ciarla discussed the advisability of a bylaw change that would establish a mechanism for the appointment or approval of the executive director of Physicians Service by the Corporation, or by a special conference committee of Blue Cross and Physicians Service. The question was discussed by legal counsel and several members of the Corporation, and the suggestion was advanced that the Board of Directors might review in the immediate future the joint operations agreement of the two plans as it affects such appointments.

Possible Consolidation of "A" and "B" Plans: Doctor Ciarla discussed the advisability of eliminating the present "A" and "B" plans of Physicians Service in favor of a single indemnity-service plan for all subscribers. The president stated that the proposal would be referred to the Board of Directors for its consideration.

Legislative Hearing on Physicians Service: Doctor William A. Reid noted that the Senate Corporations Committee plans a hearing on the legislative proposal whereby the majority of the board of directors of Physicians Service would have to be non-physician representatives of the public. He suggested a single spokesman for Physicians Service.

Doctor Ciarla moved that the president, or in his absence, the vice president be delegated as the official spokesman for Physicians Service at the hearing. Doctor Ashworth stated that he would arrange his plans so that he would be present to meet the legislative committee.

The suggestion was advanced that one of the non-physician members of the board of directors also speak at the hearings, and it was agreed by the non-physician directors that Mr. John J. Hall should be that spokesman.

Doctor Samuel Adelson indicated that he would speak for the Rhode Island Medical Society at the hearing.

Special Meeting of the Corporation: Doctor Adelson stated that he requested members of the Corporation interested in the calling of a special meeting of the Corporation, to consider a possible change of Section 7 of Article V of the bylaws to provide that the executive director be elected by a joint committee of equal Blue Cross and Physicians Service representation, meet with him upon adjournment.

Adjournment

The Thirteenth Annual Meeting of the Corporation was adjourned at 9:30 P.M.

Respectfully submitted,

ARNOLD PORTER, M.D., *Secretary*

continued on next page

Report of the Secretary

To the Members of the Corporation:

The twelfth annual meeting of the Corporation was held at the Providence Sheraton-Biltmore Hotel on January 23, 1961. The minutes of this meeting were subsequently sent to each member of the Corporation, and they are on file in the Corporation's records.

Subsequent to the Corporation meeting the Board of Directors held its annual meeting on February 20, 1961, at which time the following were elected:

Non-Physician representatives of the Board: Chelcie C. Bosland, PH.D.; J. Austin Carroll; George W. Chaplin; James R. Donnelly; John J. Hall, and Robert D. Stuart.

Physician representatives for three-year terms: Frederick C. Eckel, M.D.; Henri E. Gauthier, M.D.; Waldo O. Hoey, M.D., and Frank J. Logler, M.D.

Officers: Charles J. Ashworth, M.D., *president;* Earl J. Mara, M.D., *vice-president;* Arnold Porter, M.D., *secretary*, and James R. Donnelly, *treasurer.*

Since the previous meeting of the Corporation the Board of Directors has held six meetings, and the executive committee one. All authorized standing committees were appointed and carried out their assigned tasks during the year.

It was an extremely busy and controversial year for Physicians Service, and it was a period saddened by the death of Mr. Stanley H. Saunders, executive director of both the Hospital Service Corporation and the Rhode Island Medical Society Physicians Service Corporation since the inception of each. He gave outstanding leadership and executive administration to our program, and we are truly indebted to him for making Physicians Service one of the best operated voluntary insurance plans in the nation.

The period since the meeting of the Corporation a year ago has been highlighted by:

Progress in the study of an extended benefits program that may ultimately be included under the Physicians Service plan.

The acceptance of the supplementary program to the Federal Employees Health Benefit plan, and the completion of a successful first year of service to such employees of the basic coverage.

The state legislature's action in requiring that our Corporation include podiatrists as physicians within the meaning of the Physicians Service contract.

The hearings conducted by the state director of business regulation on the proposed rates for Blue Cross and Physicians Service.

The controversial allegations made by the state AFL-CIO of alleged abuses of Physicians Service by physicians.

The regional Blue Shield Public Relations Conference held in Providence under the sponsorship of our Corporation.

The approval of the new rate schedule for Physicians Service which provided an over-all reduction in premium assessment.

The adoption of bylaw changes to provide that all members of the board of directors shall be elected by the Corporation, that a nominations committee be named, in addition to several minor amendments.

The change in the agreement with participating physicians to allow the Corporation or the physician to terminate the agreement within 90 days instead of 13 months.

* * *

These and the many varied problems of administration of a program as sizable and as successful as Physicians Service have made many demands upon your board of directors, the claims committee, and the administrative staff. As secretary of your Corporation I am cognizant of the contributions of these persons in your behalf, and I am sure I express your sentiments when I state they have done their work well under the most trying circumstances.

Respectfully submitted,
ARNOLD PORTER, M.D., *Secretary*

Report of the Treasurer
Rhode Island Medical Society — Physicians Service
Financial Statements as of December 31, 1960 — 1961
Statement of Income and Expense

	Dec. 31, 1960	*Dec. 31, 1961*	*Increase (Decrease)*
INCOME			
Received from Subscribers	$8,227,272.58	$9,095,346.60	$868,074.02
Income from Investments	82,001.98	91,989.88	9,987.90
TOTAL INCOME	$8,309,274.56	$9,187,336.48	$878,061.92
EXPENSES			
Claim Payments	$7,958,206.12	$8,444,610.21	$486,404.09
Operating Expenses	460,162.04	531,937.87	71,775.83
TOTAL EXPENSES	$8,418,368.16	$8,976,548.08	$558,179.92
NET GAIN (OR LOSS) CREDITED TO RESERVES	($ 109,093.60)	$ 210,788.40	$319,882.00

Comparative Balance Sheet

Assets

Cash in Banks and on Hand	$ 88,578.06	$ 991,633.90	$903,055.84
Accounts Receivable	752,452.75	226,627.48	(525,825.27)
U. S. Government Bonds	2,749,163.80	2,648,121.96	(101,041.84)
TOTAL ASSETS	$3,590,194.61	$3,866,383.34	$276,188.73

Liabilities

Accounts Payable	$ 665,982.54	$ 734,574.87	$ 68,592.33
Accrued for Claims	1,245,543.00	1,274,649.50	29,106.50
Unearned Subscriptions	293,111.55	255,362.55	(37,749.00)
TOTAL LIABILITIES	$2,204,637.09	$2,264,586.92	$ 59,949.83

Reserves

Reserve for Excess Losses	$ 385,557.52	$ 601,796.42	$216,238.90
Statutory Reserve	1,000,000.00	1,000,000.00	
TOTAL RESERVES	$1,385,557.52	$1,601,796.42	$216,238.90
TOTAL LIABILITIES & RESERVES	$3,590,194.61	$3,866,383.34	$276,188.73

Distribution of Physicians Service Dollar

Surgical Medical Claims	95.8	91.9	(3.9)
Operating Expense	5.5	5.8	0.3
Added to or (taken from) Reserves	(1.3)	2.3	3.6
TOTAL SPENT	101.3	100.0	(1.3)

Comparison of Statistics — Years 1960 and 1961

	1960	*1961*	*Increase (Decrease)*
Subscribers	577,903	585,580	7,677
No. of Firms Buying Physicians Service	1,321	1,589	268
Number of Participating Physicians	976	996	20
Total of Claims Paid	$ 7,958,206.	$ 8,444,610.	$ 486,404.
Total of Claims Paid Since Start of Plan	$47,740,243.	$56,184,853.	$8,444,610.
Total Assets	$ 3,590,195.	$ 3,866,383.	$ 276,188.
Total Income	$ 8,309,275.	$ 9,187,336.	$ 878,061.
Total Reserves	$ 1,385,558.	$ 1,601,796.	$ 216,238.
Operating Expenses	$ 460,162.	$ 531,938.	$ 71,776.
Opertaing Expense %	5.5%	5.8%	0.3%
Ratio of Claims to Income	95.8%	91.9%	(3.9%)
NUMBER OF CASES PAID			
Surgeons*	98,302	101,066	2,764
Assistants*	15,151	15,818	667
Anesthetists*	31,292	32,964	1,672
Medical	19,452	20,791	1,339
X-ray & EKG	101,678	102,296	618
TOTAL	265,875	272,935	7,060
*Maternity Cases (included in above)	10,645	10,707	62
NUMBER OF MONTHS EXPENSES IN RESERVE:			
Statutory Reserve	1,000,000.	1,000,000.	
Contingency Reserve	385,558.	601,796.	216,238.
Maternity Reserve	581,338.	575,888.	(5,450.)
TOTAL RESERVES	$ 1,966,896.	$ 2,177,684.	$ 210,788.
Monthly Expenses (average for year)	$ 701,531.	$ 748,046.	$ 46,515.
Number of Months Expenses in Reserve	2.80	2.91	.11
RESERVE BELOW BLUE SHIELD REQUIREMENT BY	$ 140,306.	$ 67,324.	($ 72,982.)

DISTRICT MEDICAL SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

THE ANNUAL MEETING and election of officers for the Newport County Medical Society for 1962 was held on January 31, 1962 at the Hotel Viking with José Ramos, M.D., presiding. The following officers were elected: President, Donald B. Fletcher, M.D.; First Vice-President, Charles Serbst, M.D.; Second Vice-President, Frank Logler, M.D.; Secretary, Richard R. Knowles, M.D.; Treasurer, Janis Gailitis, M.D.; Delegates to the State Medical Society, Philomen P. Ciarla, M.D., and Charles Dotterer, M.D.; Councilor to the State Medical Society, John Malone, M.D.; Censors, Samuel Adelson, M.D., and James Callahan, M.D.

Doctor Samuel Adelson outlined the history and development of the political information committee of the Rhode Island society and urged members of the local society to take whatever action possible to defeat the King-Anderson bill and to contact their Congressional delegates relative to their feelings on social security coverage for medical care for the aged. Doctor Adelson also discussed bills currently before the State Legislature relating to health matters.

Doctor Charles Serbst discussed the law recently passed by the General Assembly and signed by Governor Notte to include chiropodists under the Physicians Service plan and estimated that the cost of chiropodists' service would approximate $150,000 per year.

Doctor Frank Logler reported on recent meetings of the Physicians Service Board of Directors and recent changes in the bylaws of the Physicians Service Corporation. He also urged that the State Medical Society organize a Rhode Island Medical Political Action Committee to inform the public of the society's position on matters relating to the public health.

The following motions were made and unanimously adopted by the society:

1. If House Resolution 13 which provides for a majority of non-physicians on the Board of Directors of the Physicians Service Corporation becomes law, the members of the Newport County Medical Society resign as participating physicians in the plan.
2. That a series of advertisements be placed in the NEWPORT DAILY NEWS to inform the people of the county of the free services rendered by local physicians and the time donated in the care of indigent and emergency room patients. The cost is to be paid for by an assessment on the members of the local society.
3. That the Newport County Medical Society recommend to the State Medical Society that a Rhode Island Medical Political Action Committee (RIMPAC) be formed and provided with an executive director (supported by an assessment on the membership of the State society) to present forcefully and in a militant manner the society's feelings regarding present and future legislation relating to health matters and to take our position to the people at election time.
4. That letters be sent to Senators Claiborne Pell and John O. Pastore and Representatives Fernand St. Germain and John Fogarty inviting them to meet on a weekend in the near future with the Newport County Medical Society so that we can discuss our strong stand against the King-Anderson bill.
5. That the public be informed through appropriate news media of our actions on resolutions 1 through 4.

RICHARD R. KNOWLES, M.D., *Secretary*

* * *

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Society was held at the Lindsey Tavern on Thursday, October 19, 1961, at 8:30 P.M. The following members were present: Doctors Billings, Hogan, Fortin, Lussier, Lappin, Hecker, Rohr, Czekanski, Jaworski, Foster, Barry, Bruno, Demopulos, Paull, Mulvaney, Raheb, Jeremiah, Sprague, Yashar, Webster, Simon, Hacking, Sod, Damarjian, Hayes, F. Hanley, and Zolmian.

The minutes of the previous meeting were read and accepted.

There were no communications.

Under new business, Doctors R. Jaworski and Jeremiah were appointed by Doctor Hogan to the Providence County Chapter of the National Foundation of Infantile Paralysis.

Also under new business, Doctor Lappin asked and was granted permission to read from the

Evening Bulletin, an article in reference to the recent Blue Cross hearings titled *To Probe Doctors' Dual Payments*. Statements were read and discussed by Doctors Webster, Jaworski, Billings, Hanley, and Cunningham. Doctor Lappin then questioned the authority of Blue Cross to read records in local hospitals. A discussion followed by Doctors Demopulos, Damarjian, and Zolmian.

The members then voted on the application of Doctor Spindell for associate membership in the Pawtucket Medical Society. He was unanimously elected. A letter was sent notifying him of this.

A letter of application from Doctor Papazian was read and referred to the Membership Committee.

The business meeting was then adjourned.

The speaker of the evening was Mr. Bryson Dawson who spoke on the Newport to Bermuda Sailing Race. Mr. Dawson also showed motion pictures which were enjoyed by all.

* * *

The regular monthly meeting of the Pawtucket Medical Society was held at the Lindsey Tavern on Thursday, November 16, 1961, at 8:30 P.M. The following members were present: Doctors Hogan, Fortin, Moreno, F. Hanley, Boucher, Sprague, Hecker, Papazian, Jeremiah, Stevens, Lussier, Liang, Masse, Rohr, Dufresne, Kelly, Hennessey, Zolmian, R. and A. Jaworski, Mulvaney, Napoli, Umstead, Webster, Sod, McCaughey, Butler, Ferguson, E. Foster, Quinn, H. Turner, Hayes, J. Koropey, Raheb, Yashar, Soche, Metcalf, and Barr.

The minutes of the previous meeting were read and accepted.

Under communications, the membership application of Doctor Sousa was presented to the Society for approval and was referred to the standing committee.

There was no new business.

Under committee reports, Doctor Earl Kelly commented on the meetings of the Medical Economics Council of the Rhode Island Medical Society and the state of organized medicine in the Blackstone Valley and the State of Rhode Island. Comments followed by Doctors Hecker, Hayes, and Webster.

Also under committee reports, a message was read by Doctor Hogan from Doctor A. Gaudet asking that all members contribute generously to the United Fund.

Business meeting was adjourned at 9:40 P.M.

The speaker of the evening was Doctor Frank Hanley who spoke on civil defense and the role of the physician in general, and the Blackstone Valley in particular. Motion pictures were shown and enjoyed by all.

* * *

The regular monthly meeting of the Pawtucket Medical Society was held at the Lindsey Tavern on Thursday, January 18, 1962, at 8:30 P.M. The following members were present: Doctors Farrell, Boucher, Fortin, Cunningham, Lussier, Masse, Mara, Rosin, Benjamin, Billings, A. and R. Jaworski, Simon, Webster, Jeremiah, E. Foster, Sod, Forgiel, Hayes, Hogan, Paull, Ferguson, Liang, Lovering, Doll, Hecker, and Hennessey.

The minutes of the previous meeting were read and accepted.

Under communications, Doctor Hogan read a letter from Doctor Adelson requesting the appointment of a committee on public information to function in co-operation with the committee of the Rhode Island Medical Society. Doctor Hogan appointed Doctors Robert Hayes (chairman), Kelly, E. Lovering, Mrs. Louis Hanna, and Mrs. A. Jaworski to this committee.

Letters were read from Doctors Rosin and Benjamin requesting a change in status from associate to active membership in the Pawtucket Medical Society. Also Doctor Israel's application for active membership in the Society was read and will be forwarded to the standing committee for further action.

Under new business, Doctor Boucher commented that the United Fund is to have a Physical Fitness Fair at McCoy Stadium. They have requested the

concluded on next page



Fuller

Memorial Sanitarium

Located on Rt. 1

South Attleboro, Massachusetts

A modern non-profit hospital for the care and treatment of nervous and emotional disorders as well as long term geriatric problems.

Physical, neurological, psychiatric and psychological examinations.

Modern recognized psychiatric therapies.

A pleasant homelike atmosphere in a beautiful and conveniently located institution.

L. A. Senseman, M.D., F.A.P.A., Medical Director
Edwin Dunlop, M.D. Michael G. Touloumtzis, M.A.
Oliver S. Lindberg, M.D. William H. Dunn, M.S.W.
W. H. Lesovsky, M.D., Ph.D.

Referred patients are seen daily (except Saturdays) 9-12 A.M., and by appointment.
R. I. Blue Cross Benefits Tel. Southgate 1-8500

Special Rates for Long-Term Care

presence of physicians at one or two booths. Comments followed by Doctors Mara and Webster. The following motion was made by Doctor Mara: "I move to appoint a committee to study the feasibility of the Pawtucket Medical Society to participate in a Physical Fitness Fair." Doctor Mara's motion was carried unanimously. Doctor Hogan appointed a committee consisting of Doctors Billings, Webster, and Papazian. Doctor Billings is chairman.

Also under new business, Doctor Forgiel made the following motion: "I move that the Pawtucket Medical Society go on record to resign from Physicians Service *en masse* if legislation is passed to remove control of the board of directors of Physicians Service from physicians." Discussion then followed by Doctors Farrell, Billings, and Hecker. Doctor Forgiel's motion was then carried unanimously.

Under old business, Doctor Sousa's application for active membership, and Doctor Papazian's application for associate membership in the Pawtucket Medical Society were voted upon and they were unanimously accepted as members.

The business meeting adjourned at 9:40 P.M.

The speaker of the evening was Doctor Charles Farrell. Doctor Farrell discussed the federal program of Aid to the Disabled. Motion pictures were shown.

ROBERT G. FORTIN, M.D., *Secretary*

* * *

WOONSOCKET DISTRICT MEDICAL SOCIETY

A regular meeting of the Woonsocket District Medical Society was held on January 17, 1962 at the Cottage Club in South Bellingham, Massachusetts.

Doctor E. L. Tremblay called the meeting to order at 8:30 P.M. Our delegates to the Rhode Island Medical Society had no report, and our Councillor, Doctor Richard Dowling, also had no report. Doctor Dowling tendered his resignation at this point because he did not have the time to attend meetings. His resignation was taken under advisement.

Doctor Saul Wittes addressed the society on the practice of reporting vital statistics in the newspaper with the statistics of doctors and of undertakers being lumped together in the same story. No action taken.

Doctor Saul Wittes also stated that the present zoning laws in Woonsocket were extremely restrictive to the physicians as to location of offices. It was his impression that doctors were limited to only one street where they might have their offices without receiving special approval of the Zoning Board. The president is to appoint a committee.

Doctor Alton P. Thomas queried the Society about what action had been taken by the police or the courts to stop the frequent stealing of doctors' bags by narcotic addicts. This has become increasingly common in the past few years. No one knew of any action. The delegates will take this matter up at the state level after they receive instruction.

Doctor Henri Gauthier reported that two bills had been brought before the State Legislature on which our Society should take immediate action. These bills have to do with the attempt to take control of the Physicians Service Plan away from the medical profession and put it in the hands of nonmedical directors; and with a plan to force Physicians Service Plan to accept chiropractors as members, and to pay them benefits as if they were M.D.'s. Doctor Gauthier suggested that the Society meet with our State Senator and Representatives and make known to them our feelings within the next two weeks.

Doctor Tremblay appointed a committee consisting of Doctors Lalor, Wittes and Staudinger to make suitable arrangements.

President Tremblay introduced Doctor Constantine Georas who was moderator of a panel discussion on *Present Cancer Therapy*. Panelists were: Doctor Louis Leone, director, Cancer Research, Rhode Island Hospital; Doctor Francis Conklin, X-ray therapist, Rhode Island Hospital, and Doctor George Coleman, a Providence surgeon who specializes in cancer surgery.

After a stimulating and informative series of talks and open discussion, the meeting adjourned at 11:00 P.M.

ALTON P. THOMAS, M.D., *Secretary*

Rhode Island---Psychiatric Residencies

2-year approved active training program. Somatic therapies, psychotherapy, individual groups. Individual supervision by Diplomates of American Board. Child psychiatry affiliation. $5,750 yearly, maintenance. E.C.F.M.G. certification required. Superintendent, State Hospital, Howard, Rhode Island.

HAVE YOU CHECKED THE DATES?

Sesquicentennial Meeting

at

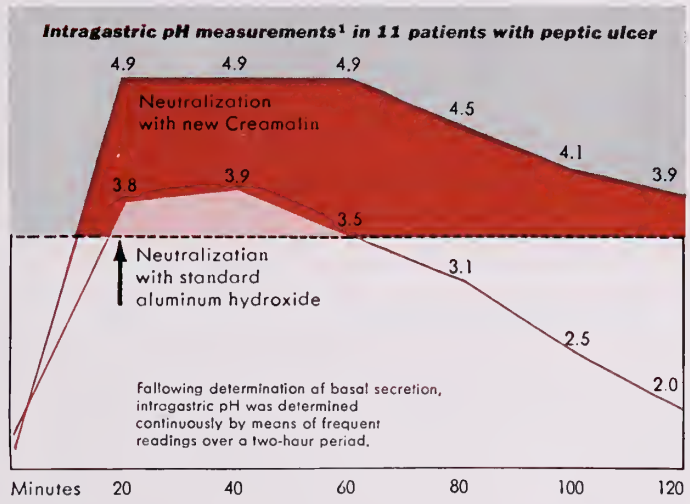
Brown Gymnasium

MAY 8 and 9, 1962

Acts as well in people as in test tubes

in vivo
neutralizes
40 to 50 per cent
faster—
twice as long at
pH 3.5 or above





New Creamalin®

Antacid Tablets

Buffers fast[1-4] for fast relief of pain—
takes up more acid

Heals ulcer fast—action more prolonged *in vivo*

Has superior action of a liquid, with the convenience of a tablet[5]

Each new Creamalin antacid tablet contains 320 mg. of specially processed, highly reactive dried aluminum hydroxide gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. New Creamalin tablets are pleasant tasting and smooth, not gritty. They do not cause constipation or electrolyte disturbance.

Dosage: Gastric hyperacidity—from 2 to 4 tablets as needed. Peptic ulcer or gastritis—from 2 to 4 tablets every two to four hours.

How Supplied: Creamalin Tablets, bottles of 50, 100, 200 and 1000. Also available: New Creamalin Liquid (1 teaspoon=1 tablet), bottles of 8 and 16 fl. oz.

References: **1.** Schwartz, I. R.: *Current Therap. Res.* 3:29, Feb., 1961. **2.** Beekman, S. M.: *J. Am. Pharm. A.* (Scient. Ed.) 49:191, April, 1960. **3.** Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:381, July, 1959. **4.** Data in the files of the Department of Medical Research, Winthrop Laboratories. **5.** Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:384, July, 1959.

Winthrop LABORATORIES
New York 18, N.Y.

FOR PEPTIC ULCER • GASTRITIS • GASTRIC HYPERACIDITY



To help you and your family build systematically and surely for the future

A new type of trust service from Industrial National Bank

THE BUDGET TRUST

NOW INDUSTRIAL NATIONAL offers you a personal budget plan to help you build for the future — a budget plan you can start on right now! It's a new type of trust service — *The Budget Trust.*

How your Budget Trust works

You start your Budget Trust with $100 or more. Then you make regular planned deposits. It may be as little as $25 a month.

Your funds are invested in common stocks selected primarily with an eye to long-term growth rather than current income. Your lawyer draws the Trust Agreement — and Industrial National acts as your trustee. All income earned is added to your Budget Trust and reinvested. The continuous inflow of funds gives you the maximum advantage of dollar-cost-averaging.

Flexibility of your Budget Trust

Your Budget Trust is revocable at any time, in part or in whole. You may withdraw any part of your funds on quarterly withdrawal and entry dates.

You will discover, though, that a Budget Trust — with its systematic deposit feature — will make it much easier for you to accumulate the funds you need for your long-range goals. It's something important to consider when you think ahead to your retirement, your children's education, or any other years-from-now project.

Your Budget Trust brings you the benefits of Industrial National's broad investment and trust experience. One of our trust officers will be glad to discuss the new Budget Trust with you. To learn more about the Budget Trust, visit any Industrial National office, or call Mr. Allingham at JA 1-9700.

INDUSTRIAL
NATIONAL BANK OF
RHODE ISLAND

45 Neighborhood Offices Serving Rhode Island

Member Federal Reserve System
Member Federal Deposit Insurance Corporation

APRIL, 1962

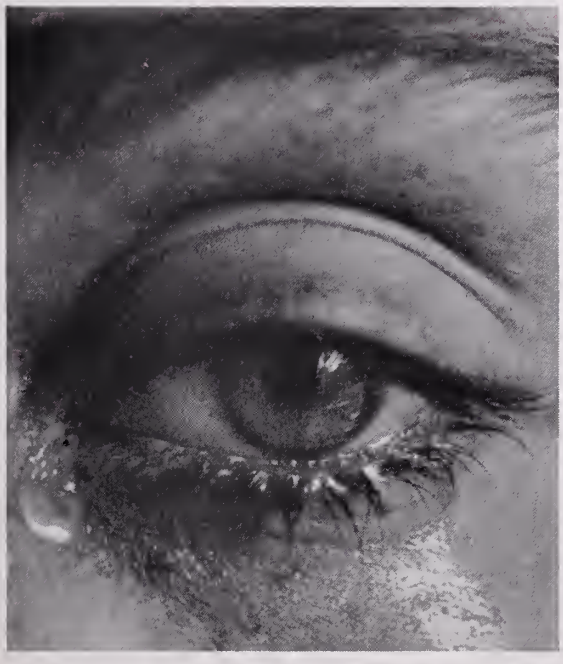
RHODE ISLAND

Medical Journal

Sesquicentennial Meeting
Marvel Gymnasium
May 8 and 9, 1962
. . . See page 180

Volume XLV, No. 4
Table of Contents, page 179

THE N Y ACA... OF MED...
MAY - ... 1962
LIBRARY



A CASE FOR HALDRONE®
(paramethasone acetate, Lilly)

In acute cases of ALLERGY, Haldrone produces rapid remission of symptoms with little adverse effect on electrolyte metabolism.

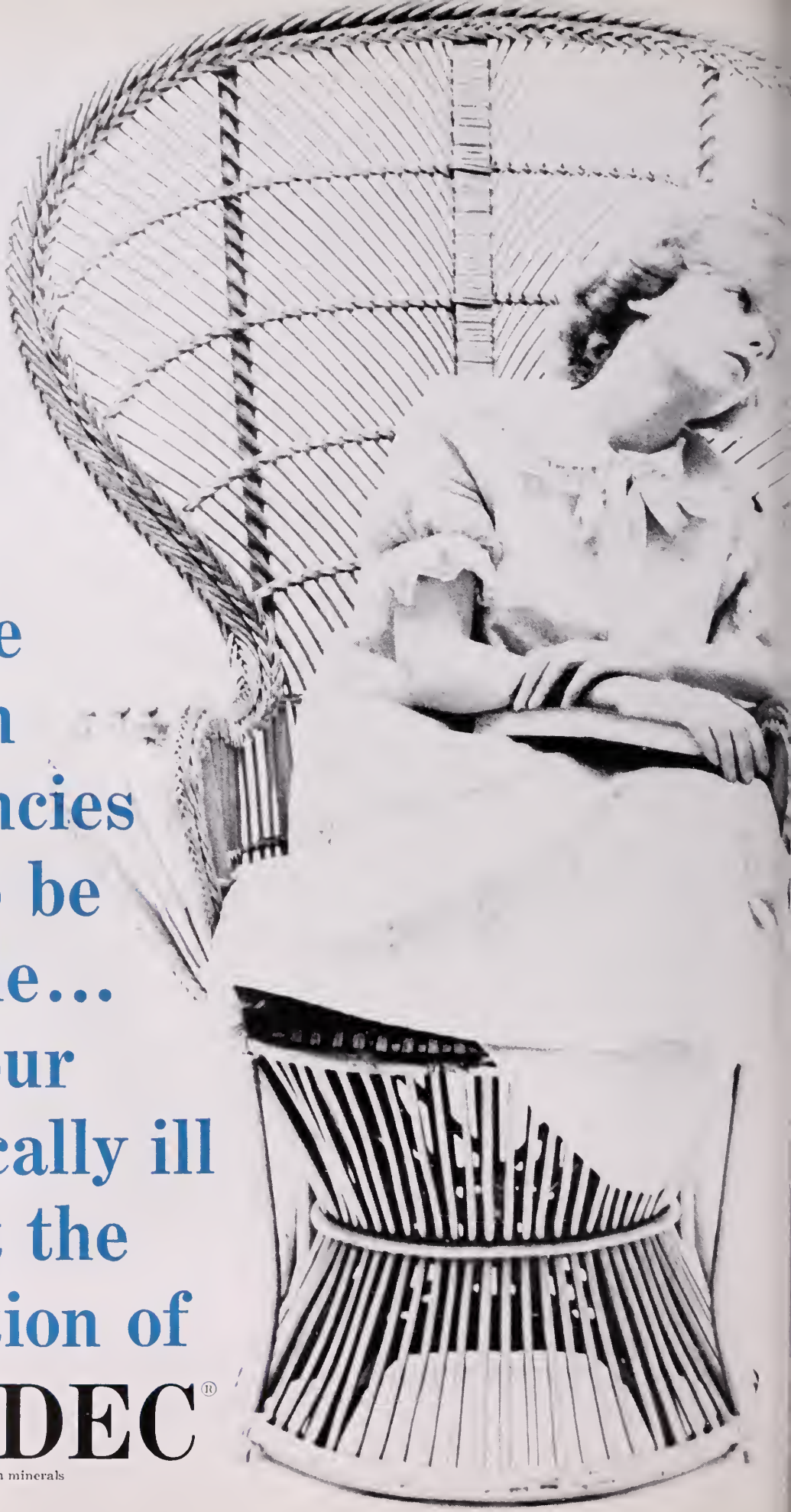
This is a reminder advertisement. For adequate information for use, please consult manufacturer's literature. Eli Lilly and Company, Indianapolis 6, Indiana.

Lilly

240030

Suggested daily dosage in hay fever:
Initial suppressive dose. . 4-8 mg.
Maintenance dose . . . . 2-4 mg.

Supplied in bottles of 30, 100, and 500 tablets:
1 mg., Yellow (scored)
2 mg., Orange (scored)



because vitamin deficiencies tend to be multiple... give your chronically ill patient the protection of

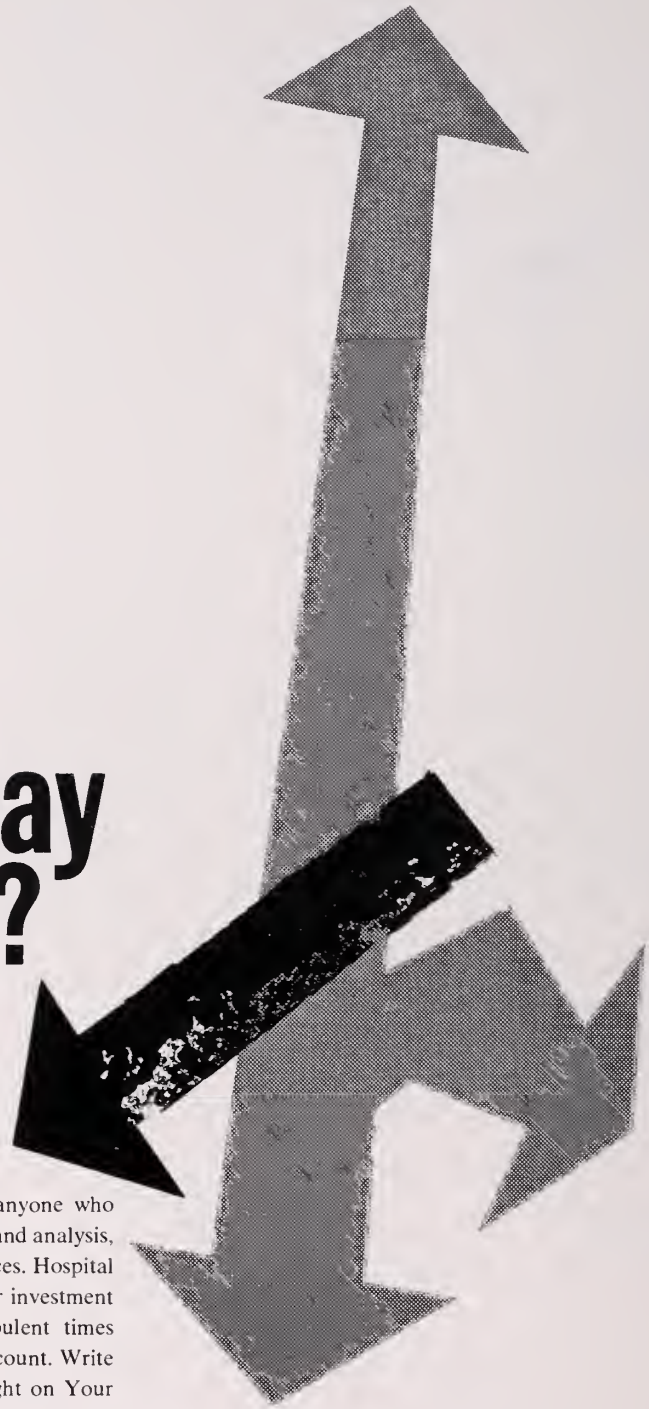
MYADEC®

high-potency vitamin formula with minerals

It is generally accepted that diseases of long standing and other conditions of physiologic stress may produce a need for additional vitamins. MYADEC is designed to supply that need. Just one capsule a day provides therapeutic potencies of 9 vitamins, plus selected minerals normally present in body tissues. MYADEC is also useful for the *prevention* of vitamin deficiencies in patients whose usual diets are lacking in these important food factors.

Each MYADEC capsule contains: *Vitamins:* Vitamin B_{12}, crystalline—5 mcg.; Vitamin B_2 (riboflavin)—10 mg.; Vitamin B_6 (pyridoxine hydrochloride)—2 mg.; Vitamin B_1 mononitrate—10 mg.; Nicotinamide (niacinamide)—100 mg.; Vitamin C (ascorbic acid)—150 mg.; Vitamin A—(7.5 mg.) 25,000 units; Vitamin D—(25 mcg.) 1,000 units; Vitamin E (*d*-alpha-tocopheryl acetate concentrate)—5 I.U. *Minerals* (as inorganic salts): Iodine—0.15 mg.; Manganese—1 mg.; Cobalt—0.1 mg.; Potassium—5 mg.; Molybdenum—0.2 mg.; Iron—15 mg.; Copper—1 mg.; Zinc—1.5 mg.; Magnesium—6 mg.; Calcium—105 mg.; Phosphorus—80 mg. Bottles of 30, 100, and 250.

PARKE-DAVIS
83562
PARKE, DAVIS & COMPANY, Detroit 32, Michigan



which way to move?

Not an easy question for a busy investor at this moment in the world's history. It is hard to judge the dangers; harder still to see the opportunities that can serve to balance them . . . opportunities that arise even in days like these. Particularly hard for anyone who lacks either the time for searching study and analysis, or information in depth from many sources. Hospital Trust has both; let us help you keep your investment program in balance during these turbulent times through an Investment Management Account. Write or stop in for our free booklet, "Spotlight on Your Investments." It tells in detail just how an Investment Management Account will benefit you.

RHODE ISLAND
HOSPITAL TRUST COMPANY

New England's Oldest Trust Company

The RHODE ISLAND MEDICAL JOURNAL

Editorial and Business Office: 106 Francis Street, Providence, R. I.

Editor-in-Chief: SEEBERT J. GOLDOWSKY, M.D.

Managing Editor: JOHN E. FARRELL, SC.D.

Senior Editors

ALEX M. BURGESS, SR., M.D. HENRI E. GAUTHIER, M.D.

Advisory Board

(in addition to editors listed above)

JOHN A. DILLON, M.D. JOHN F. W. GILMAN, M.D. ROBERT V. LEWIS, M.D.
PETER L. MATHIEU, M.D. JOSÉ M. RAMOS, M.D. ROBERT W. RIEMER, M.D.
JACK SAVRAN, M.D. LESTER L. VARGAS, M.D.

Owned and Published Monthly by
THE RHODE ISLAND MEDICAL SOCIETY
Second-class postage paid at Providence, Rhode Island

Copyright, 1962, the Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island
Single copies, 25 cents . . . Subscription, $2.00 per year.

Volume XLV, No. 4 April, 1962

TABLE OF CONTENTS

PAGE

PNEUMATOSIS INTESTINALIS — A MEDICAL AND SURGICAL PROBLEM, *Arseno C. Pascual,* M.D., *John R. Stuart,* M.D., AND *Waldo O. Hoey,* M.D. 193

PHEOCHROMOCYTOMA AND HYPERTHYROIDISM, A Case Report, *Raymond E. Moffitt,* M.D.; *Daniel S. Liang,* M.D.; *Frank Jadosz,* M.D., AND *Adolfo Lizarraga,* M.D. 197

JUNGLE HOSPITAL, *Meyer Saklad,* M.D. 200

BRONCHOTOMY FOR OBSTRUCTION OF THE AIRWAY DURING THORACIC SURGERY, *Albin N. Grenda,* M.D., AND *Harold W. Harrower,* M.D. 205

SOLITARY EOSINOPHILIC GRANULOMA OF BONE IN A SIXTY-SEVEN-YEAR-OLD MALE, *Stanley D. Simon,* M.D., AND *Caroll M. Silver,* M.D. 208

THE MEDICAL EDUCATION LOAN GUARANTEE PROGRAM OF THE A.M.A. 214

H.R. 4222: COMPULSORY HEALTH TAXATION 220

EDITORIALS

The Sesquicentennial Meeting 211

The Surgical Assistant 211

The Fifth Baxter Lecture 213

DEPARTMENTS

Sesquicentennial Meeting Program 180

The Washington Scene 188

District Medical Society Meetings 218

Through the Microscope 222

Scanning the Medical Literature 226

PROGRAM OF THE SESQUICENTENNIAL MEETING
of the
RHODE ISLAND MEDICAL SOCIETY

May 8 and 9, 1962 — *Marvel Gymnasium, Brown University*

TUESDAY, MAY 8

9:00 A.M. REGISTRATION

9:30 A.M.-1:30 P.M. MEDICAL MOTION PICTURES

1:30 P.M. CALL TO ORDER

Greetings: SAMUEL ADELSON, M.D., President
The Rhode Island Medical Society

Greetings: BARNABY C. KEENEY, President
Brown University

1:45 P.M. "MEDICAL EDUCATION AND BROWN UNIVERSITY"

GLIDDEN L. BROOKS, M.D.
of Providence, Rhode Island
(Director, Institute for Health Sciences, Brown University)

2:15 P.M. "ONE HUNDRED AND FIFTY YEARS OF MEDICAL PRACTICE IN RHODE ISLAND"—A SYMPOSIUM ON THE HISTORY OF THE RHODE ISLAND MEDICAL SOCIETY

BY RHODE ISLAND PHYSICIANS
SEEBERT J. GOLDOWSKY, M.D.
PHILIP BATCHELDER, M.D.
WILFRED PICKLES, M.D.

3:00 P.M. INTERMISSION. TOUR OF SCIENTIFIC AND TECHNICAL EXHIBITS

3:30 P.M. "PANCREATITIS DISEASE—ITS DIAGNOSIS AND SURGICAL MANAGEMENT"

JOHN M. HOWARD, M.D.
of Philadelphia, Pennsylvania
(Professor of Surgery, Hahnemann Medical College; co-author, SURGICAL DISEASES OF THE PANCREAS

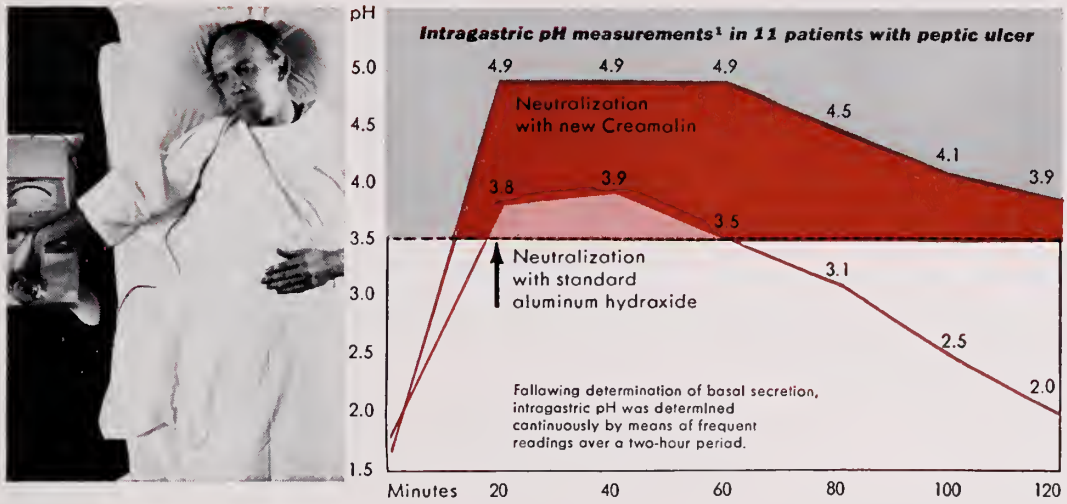
4:00 P.M. "CHRONIC BRONCHITIS AND EMPHYSEMA"

EDWARD GAENSLER, M.D.
of Boston, Massachusetts
(Associate Professor of Surgery, Boston University School of Medicine)

continued on page 182

Acts as well in people as in test tubes

in vivo
neutralizes
40 to 50 per cent
faster—
twice as long at
pH 3.5 or above



New Creamalin®

Antacid Tablets

Buffers fast[1-4] for fast relief of pain—
takes up more acid

Heals ulcer fast—action more prolonged *in vivo*

Has superior action of a liquid, with the convenience of a tablet[5]

Each new Creamalin antacid tablet contains 320 mg. of specially processed, highly reactive dried aluminum hydroxide gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. New Creamalin tablets are pleasant tasting and smooth, not gritty. They do not cause constipation or electrolyte disturbance.

Dosage: Gastric hyperacidity—from 2 to 4 tablets as needed. Peptic ulcer or gastritis—from 2 to 4 tablets every two to four hours.

How Supplied: Creamalin Tablets, bottles of 50, 100, 200 and 1000. Also available: New Creamalin Liquid (1 teaspoon=1 tablet), bottles of 8 and 16 fl. oz.

References: **1.** Schwartz, I. R.: *Current Therap. Res.* 3:29, Feb., 1961. **2.** Beekman, S. M.: *J. Am. Pharm. A.* (Scient. Ed.) 49:191, April, 1960. **3.** Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:381, July, 1959. **4.** Data in the files of the Department of Medical Research, Winthrop Laboratories. **5.** Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:384, July, 1959.

Winthrop LABORATORIES
New York 18, N.Y.

FOR PEPTIC ULCER • GASTRITIS • GASTRIC HYPERACIDITY

PROGRAM OF THE SESQUICENTENNIAL MEETING

continued from page 180

TUESDAY, MAY 8

4:30 P.M. "THE MANAGEMENT OF STROKES DUE TO EXTRACRANIAL ATHEROSCLEROSIS"

CHARLES ROB, M.D.
of Rochester, New York

(Chairman, Department of Surgery, University of Rochester School of Medicine; President, International Cardiovascular Society; Late Professor of Surgery, University of London, England, and Director of the Surgical Unit, St. Mary's Hospital, London)

5:00 P.M. RECESS. TOUR OF THE SCIENTIFIC AND TECHNICAL EXHIBITS

7:00 P.M. REGISTRATION. TOUR OF EXHIBITS

8:15 P.M. CALL TO ORDER

Presiding: SAMUEL ADELSON, M.D., President
Rhode Island Medical Society

ADDRESS

HONORABLE JOHN O. PASTORE
United States Senator from Rhode Island

9:00 P.M. THE CHARLES VALUE CHAPIN ORATION
"ERADICATION OF POLIOMYELITIS — PRESENT STATUS AND FUTURE PROSPECTS"

ALBERT B. SABIN, M.D.
of Cincinnati, Ohio

(Distinguished Service Professor of Research Pediatrics, University of Cincinnati College of Medicine; Chief, Division of Infectious Diseases, The Children's Hospital Research Foundation, Cincinnati, Ohio)

* * *

AWARD OF THE CITY OF PROVIDENCE DOCTOR CHARLES VALUE CHAPIN MEDAL TO DOCTOR ALBERT B. SABIN

HONORABLE WALTER H. REYNOLDS
Mayor of the City of Providence

10:15 P.M. TOUR OF THE SCIENTIFIC AND TECHNICAL EXHIBITS

WEDNESDAY, MAY 9

9:30 A.M. REGISTRATION

10:00 A.M.-12:00 NOON 1:00-2:00 P.M. MEDICAL MOTION PICTURES

12:00 NOON PRESIDENTIAL ADDRESS

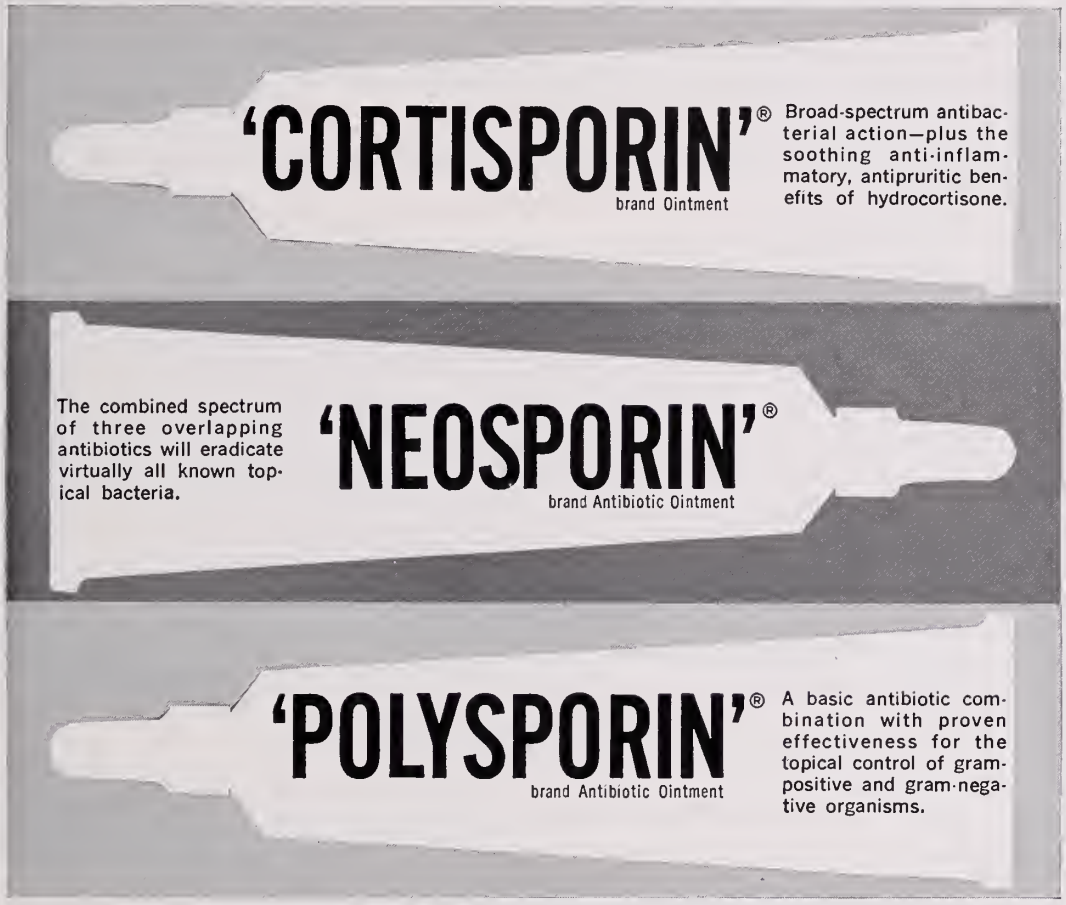
SAMUEL ADELSON, M.D.
of Newport, Rhode Island

12:30 P.M. PRESENTATION OF SCIENCE FAIR AWARDS
ANNUAL GENERAL MEETING OF THE SOCIETY
INDUCTION OF OFFICERS FOR 1962-1963

1:00 P.M. LUNCHEON AND TOUR OF EXHIBITS

concluded on page 184

'B. W. & Co.' 'Sporin' Ointments rarely sensitize . . . give decisive bactericidal action for most every topical indication



Contents per Gm.	'Polysporin'®	'Neosporin'®	'Cortisporin'®
'Aerosporin'® brand Polymyxin B Sulfate	10,000 Units	5,000 Units	5,000 Units
Zinc Bacitracin	500 Units	400 Units	400 Units
Neomycin Sulfate	—	5 mg.	5 mg.
Hydrocortisone	—	—	10 mg.
Supplied:	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of ½ oz. and ⅛ oz. (with ophthalmic tip)

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

PROGRAM OF THE SESQUICENTENNIAL MEETING

concluded from page 182

2:00 P.M. FISK PRIZE ESSAY

"CURRENT STATUS OF OPEN HEART SURGERY"

LESTER L. VARGAS, M.D.

of Providence, Rhode Island

(Surgeon-in-Chief, Department of Surgery, Rhode Island Hospital; Director of the Cardiovascular Surgical Research Laboratory; Assistant Clinical Professor of Surgery, Tufts University School of Medicine)

2:30 P.M. "RECENT DEVELOPMENTS IN THE CHEMOTHERAPY OF INFECTION"

LOUIS WEINSTEIN, M.D.

of Boston, Massachusetts

(Professor of Medicine, Tufts University School of Medicine)

3:00 P.M. "TISSUE TRANSPLANTATION: SOME POSSIBLE AVENUES TOWARD A CLINICAL SOLUTION OF THE HOMOGRAFT PROBLEM"

PAUL S. RUSSELL, M.D.

of New York, New York

(Associate Professor, Department of Surgery, Columbia University; Attending Surgeon, Presbyterian Hospital, and Associate Visiting Surgeon, Francis Delafield Hospital)

3:30 P.M. RECESS. TOUR OF EXHIBITS

4:00 P.M. PANEL PRESENTATION

1. "DIAGNOSIS OF ADRENAL DISEASE"

GEORGE F. CAHILL, JR.

of Boston, Massachusetts

(Director, Endocrine Metabolic Unit, Peter Bent Brigham Hospital, and Associate in Medicine, Harvard Medical School)

2. "CURRENT CONCEPTS OF DIABETES MELLITUS"

ALBERT E. RENOLD, M.D.

of Boston, Massachusetts

(Director, Baker Clinic Research Laboratory, and Assistant Professor of Medicine, Harvard Medical School)

3. "MANAGEMENT OF COMMON THYROID PROBLEMS"

HERBERT A. SELENKOW, M.D.

of Boston, Massachusetts

(Director of Thyroid Laboratory, Peter Bent Brigham Hospital; Clinical Associate in Medicine, Harvard Medical School)

5:30 P.M. RECESS. TOUR OF EXHIBITS

6:00 P.M. RECEPTION AND SOCIAL HOUR. SHERATON-BILTMORE HOTEL FOYER

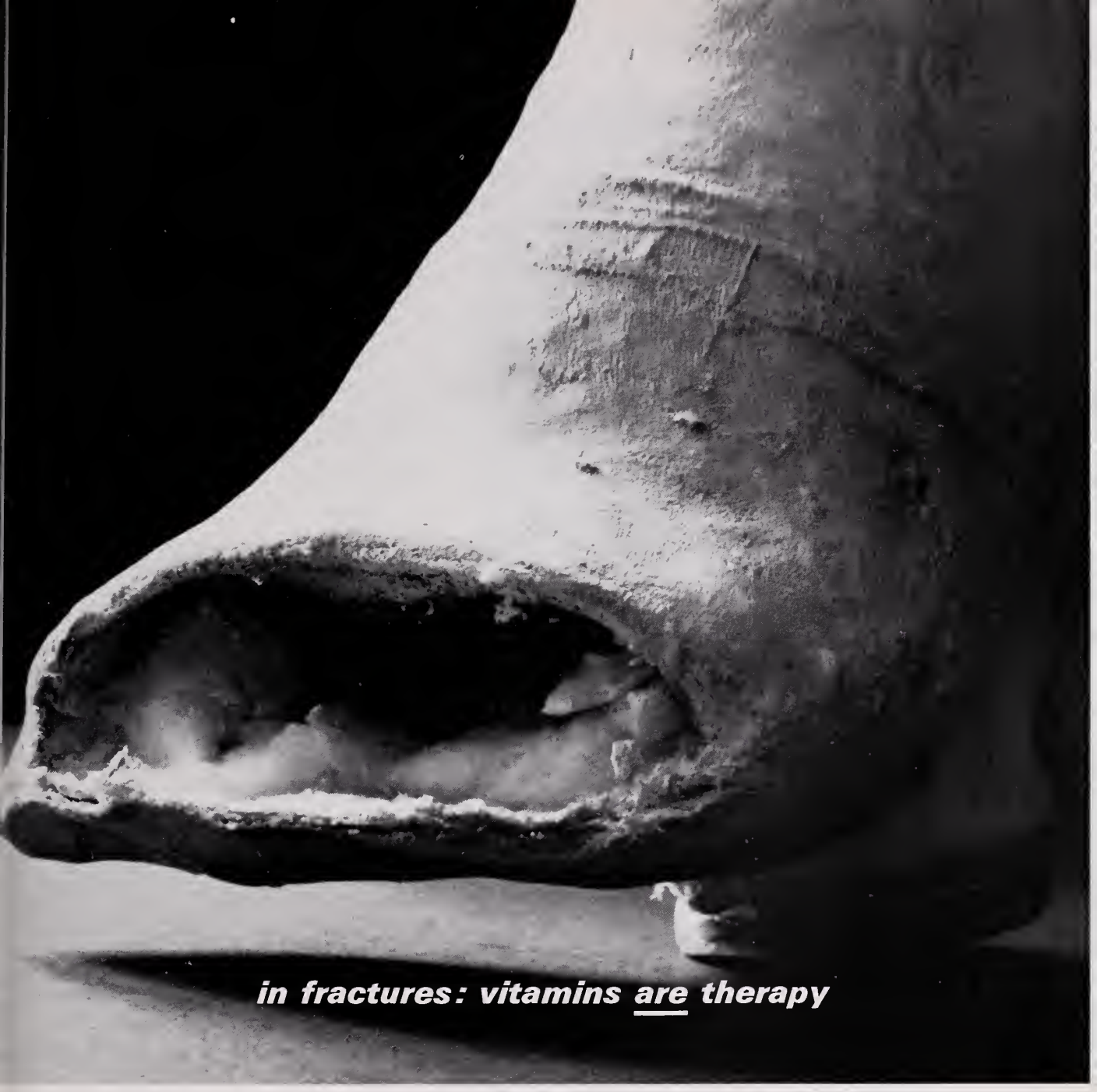
7:00 P.M. ANNUAL DINNER. SHERATON-BILTMORE HOTEL BALLROOM

8:30 P.M. ADDRESS: "CURRENT MEDICAL LEGISLATIVE PROBLEMS

EDWARD R. ANNIS, M.D.

of Miami, Florida

(Attending Surgeon, Mercy Hospital, Visiting Surgeon, Jackson Memorial and Variety Children's hospitals, Miami; Visiting Surgeon, St. Francis Hospital, Miami Beach; Chairman, Legislative Committee, Florida State Medical Association; Chairman, Speakers' Bureau, A.M.A.; Editor-at-Large, MEDICAL ECONOMICS; author and debater)



Few factors are more fundamental to tissue and bone healing than nutrition. Therapeutic allowances of B and C vitamins are important for rapid replenishment of vitamin reserves which may be depleted by the stress of fractures. Metabolic support with STRESSCAPS is a useful adjunct to an uneventful recovery. Supplied in decorative "reminder" jars of 30 and 100.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.

STRESSCAPS®

Stress Formula Vitamins Lederle



Coca-Cola, too, is compatible with a well balanced diet. As a pure, wholesome drink, it provides a bit of quick energy ... brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE-MARK ®



Wherever you go forget your telephone calls. We'll take them for you, day or night.

MEDICAL BUREAU

of the

Providence Medical Association

The extra-firm mattress selected by over 9,000 doctors for their own use

Assures both preventive and corrective support—used in more American homes than any other special design

Sealy Posturepedic is the first mattress designed in cooperation with leading orthopedic surgeons to promote normal, healthful sleep among *all* persons.

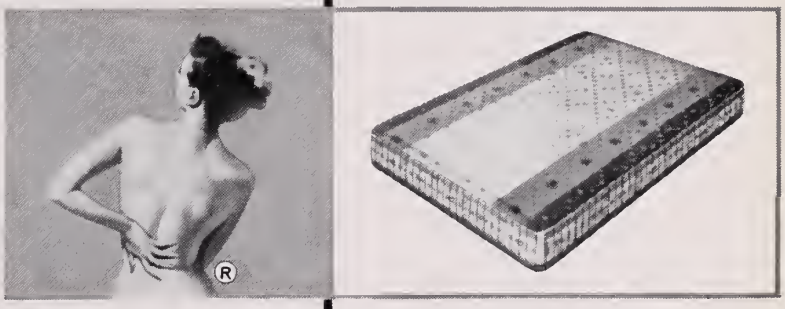
As a "corrective device" it serves those chronically afflicted with lower back syndromes. As a preventive measure Sealy Posturepedic brings deep spring buoyancy without bedboard hardness to everyone—plus the concomitant blessings of unexcelled comfort and extra-firm support.

These are basic to good health. The therapeutic value of restful sleep is especially recognized during these tense and anxious days. Sealy Posturepedic eminently meets this need by supplying level spine support for proper relaxation of the limbs and human musculatory system.

Over 9,000 doctors of medicine have tried and bought the Sealy Posturepedic mattress and matching foundation for their own use. We believe your investigation will firmly convince you of its distinctive benefits, and, we would hope, merit your valued recommendation.

Sealy POSTUREPEDIC®
BRAND

NO MORNING BACKACHE
from a too-soft mattress



PROFESSIONAL DISCOUNT OF $39.00

So that you may judge the quality of the Sealy Posturepedic for yourself, we offer a special Professional Discount on this mattress and foundation when purchased for your personal use. *Limit—one full or two twin size sets.*

SEALY MATTRESS COMPANY • Oakville, Conn.

Enclosed is my check and letterhead. Please ship the Sealy Posturepedic Set(s) indicated below:

1 Full Size ☐ **1 Twin Size** ☐ **2 Twin Size** ☐

	RETAIL		PROFESSIONAL
Posturepedic Mattress	each $79.50	(add state tax)	$60.00
Posturepedic Foundation	each $79.50	(add state tax)	$60.00

NAME_____

RESIDENCE_____

CITY_____ ZONE____ STATE_____

(This is a saving of $39.00 per set over the regular $159.00 retail price for mattress and matching foundation)

©Sealy, Inc., 1958

THE WASHINGTON SCENE

A Summary Report Issued by the Washington Office of the American Medical Association

THE AMERICAN MEDICAL ASSOCIATION said that President Kennedy misstated the real issue when he renewed his request to Congress for legislation that would provide limited health care for the aged under social security.

"We believe the American people are entitled to know that the real issue is not medical care versus no medical care for the elderly," Doctor Leonard W. Larson, president of the A.M.A. said.

"The real issue is: should wage earners and employers be forced to pay a substantial increase in taxes to provide medical care for millions financially able to take care of themselves?

"No one supporting this proposal has yet presented any evidence that such radical legislation is needed.

"The medical profession is for the Kerr-Mills law to help the aged who need help. We are for voluntary enterprise, including health insurance and prepayment plans for the non-needy aged."

Doctor Larson also disputed other statements on the issue which President Kennedy made in a new health message to Congress. Doctor Larson said that contrary to what Mr. Kennedy said, the Administration legislation (the King-Anderson bill) could interfere with the patient's freedom of choice of hospital and physician.

It would give the federal government "such broad power to control the practice of medicine in the nation's hospitals that the secretary of Health, Education and Welfare would literally become the czar of American medicine," Doctor Larson said.

Doctor Larson also pointed out that it would not be a health insurance program as President Kennedy said. Instead, it was "political medicine," Doctor Larson said.

"As the Supreme Court of the United States has ruled, Social Security is strictly a tax program with current taxes used principally to provide benefits for those now retired," Doctor Larson said.

President Kennedy's new health message was a summation of various Administration proposals in the field with some additions. It included:

—Federal aid for construction of medical schools and scholarships for medical students.

—Expanded health research, including a new institute for child health and human development.

—More funds for the National Institute of Mental Research.

—Federal loans to help set up group practice clinics.

—Encouragement of states to provide medical services for migrant workers.

—Federal research and grants to help combat air pollution in cities.

—A three-year program of federal assistance to get American children vaccinated against polio, diphtheria, whooping cough and tetanus. The government would pay the cost of vaccines for all children under five, provided state and local communities set up inoculation programs.

—Establishment of a National Environmental Health Center "to provide a focal point for nationwide activities in the control of air pollution, water pollution, radiation hazards, and occupational hazards."

* * *

A broad investigation of cold remedies to determine whether their advertising overstates their effectiveness has been started by the Federal Trade Commission.

As a start, the Commission sent questionnaires to 24 major manufacturers of cold remedies. Answers to the questionnaires are mandatory under the Federal Trade Commission Act. When and how many additional manufacturers will receive similar questionnaires has not yet been determined.

The answers to the questionnaires will enable the Commission to make a comprehensive review of problems throughout the entire field and will assist in evaluating scientific evidence claimed for the medicinal preparations.

The survey seeks information on all such preparations offered for the relief or treatment of congestion, irritation, inflammation, infection, allergy or other conditions involving any part of (1) head, including the accessory nasal sinuses, (2) throat, (3) bronchiti, (4) chest, or other portions of the respiratory system. The questionnaires also seek information on claims for the relief or treatment of any symptom or manifestation of these ailments.

The Commission's resolution stated that it had reason to believe that certain corporations in offering such products to the public "may have falsely advertised and misrepresented" their efficacy. The resolution added that the public interest required that an investigation be conducted to determine

concluded on page 190



"cramps" don't cramp her style...

when you prescribe

Trancoprin®

Aspirin.....(5 grains) 300 mg.
Trancopal® (brand of chlormezanone).....50 mg.

Trancoprin is more than a simple analgesic: It deals with cramping pains in three ways. Besides dimming pain perception, Trancoprin, through its tranquilizing action, reduces anxiety and raises the tolerance for discomfort. And, against the spasm caused by pain which, in turn, produces more pain, Trancoprin exerts its skeletal muscle relaxant action.

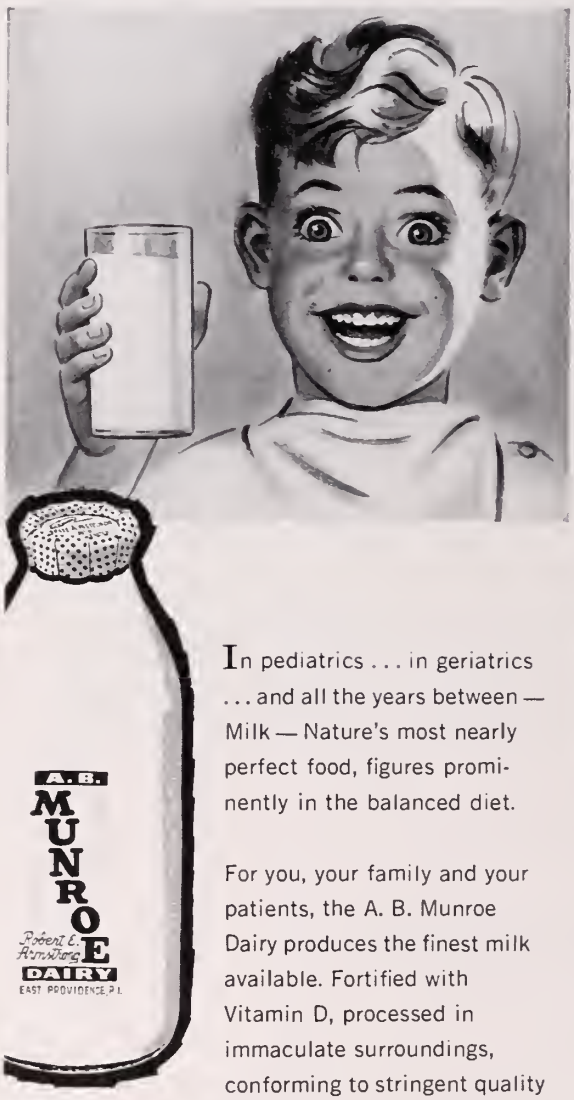
Trancoprin is exceptionally safe to use: Fewer than two and a half per cent of patients can be expected to have any side effects, and these are of a minor nature.

Available in bottles of 100 tablets. The usual dosage in dysmenorrhea is 2 tablets 3 or 4 times daily.

Winthrop LABORATORIES, New York 18, N.Y.

Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications. 1602M

"your very good health"



In pediatrics . . . in geriatrics . . . and all the years between — Milk — Nature's most nearly perfect food, figures prominently in the balanced diet.

For you, your family and your patients, the A. B. Munroe Dairy produces the finest milk available. Fortified with Vitamin D, processed in immaculate surroundings, conforming to stringent quality requirements, A. B. Munroe milk is the ultimate in purity and safety.

RHODE ISLAND QUALITY MILK ASSOCIATION MEMBER

A. B. MUNROE DAIRY, INC.
151 Brow Street, East Providence, Rhode Island

Call GE 8-4450
for Home Delivery

THE WASHINGTON SCENE

concluded from page 188

whether such advertising was in violation of the Federal Trade Commission Act.

The names of the twenty-four manufacturers to whom the questionnaires were sent will not be disclosed, an FTC spokesman said.

Legislative Roundup

NEW KENNEDY LINE . . . Look for President Kennedy to claim in future talks that H.R. 4222 is not the opening wedge for socialized medicine . . . Rep. Cecil King (R., Calif.) who introduced the bill reported on March 20 that he had talked to the President and asked him to help "dispel the idea" that his bill would take the country toward socialized medicine . . . King contended that the A.M.A. was using "unfair tactics" in labeling H.R. 4222 as such.

WHAT IT MEANS . . . The request by Rep. King and the President's remarks indicate that the socialized medicine tag on H.R. 4222 is hurting them . . . It also shows that the President is "whistling by the graveyard" when he says that medicine's "case is lost."

SOCIALIZED MEDICINE DEFINED . . . Webster's NEW COLLEGIATE DICTIONARY gives this definition of socialized medicine: "Administration by an organized group, a state, or a nation of medical and hospital services to suit the needs of all members of a class or classes or all members of the population, deriving funds from assessments, philanthropy, taxation, or other sources." . . . H.R. 4222 would provide health services, mainly in hospitals, to all aged on social security, regardless of their financial status . . . Former Rep. Aimé Forand, who has long campaigned for health care of the aged through social security, has stated publicly that "if we can only break through and get our foot inside the door, then we can expand the program after that." . . . Forand was referring to his own measure, H.R. 4700, 86th Congress . . . However, he now heads the National Senior Citizens Council for Health Care Through Social Security which is staging a rally in New York on May 20 at which Mr. Kennedy will speak.

CURTIS ANSWERS KING . . . On March 20, Rep. Thomas B. Curtis (R., Mo.) answered Rep. King who had criticized A.M.A.'s testimony on H.R. 4222 and inserted a lengthy rebuttal in the Congressional Record . . . Rep. Curtis accused King of using "deceptive words" in describing H.R. 4222 as "health insurance." . . . He said constant reference to H.R. 4222 as a health insurance program had led many people who would not be helped by the bill to write in to support the measure . . . Actually, said Curtis, "less than 25% of the average health costs" would be covered under H.R. 4222.

"How are things now, Miss G.?" "You know, Doctor... I didn't feel anything, but my boss says I'm easier to get along with... I act like I used to..." "Feel sleepy during the day? Eating well?" "No... really on my toes... good appetite."

ne treatment of mild to moderate ten- and anxiety, the normalizing effect of IDONE leaves the patient emotionally le, mentally alert. Adult dose: One ng. tablet, four times daily. Supplied: -scored tablets, 400 mg., bottle of 50.

this could be your "anxiety patient" on

TREPIDONE®

MEPHENOXALONE LEDERLE

est complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

DERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle



LOMOTIL®

(brand of diphenoxylate hydrochloride with atropine sulfate)



ANTIDIARRHEAL TABLETS and LIQUID

lowers motility / relieves cramping / controls diarrhea

Roentgenographic studies by Demeulenaere[1] established that a single dose of 10 mg. of Lomotil slowed gastrointestinal transit within two hours and that it maintained its decelerating activity for more than six hours.

In diarrhea this lowered propulsion permits a physiologic absorption of excess fluid, lessens frequency and fluidity of stools and gives safe, selective, symptomatic control of most diarrheas. Concurrently, it conserves electrolytes and controls cramping.

Investigators have found the antidiarrheal action of Lomotil not only "excellent"[2] but "efficacious[3] where other drugs have failed. . . ."

DOSAGE: For *adults* the recommended initial dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is under control. Maintenance dosage may be as low as two tablets daily. For *children* daily dosages, in divided doses, range from 3 mg. (½ teaspoonful three times daily) for infants 3 to 6 months to 10 mg. (1 teaspoonful five times daily) for children 8 to 12 years. Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg. and as liquid containing 2.5 mg. in each 5 cc. A subtherapeutic amount of atropine sulfate (0.025 mg.) is added to each tablet and each 5 cc. of the liquid to discourage deliberate overdosage. The recommended dosage schedules should not be exceeded.

NOTE: Lomotil is an exempt narcotic preparation.

Descriptive literature and directions for use detailed in Physicians' Product Brochure No. 81 available from G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.

1. Demeulenaere, L.: Action du R 1132 sur le transit gastrointestinal, Acta Gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.
2. Kasich, A. M.: Treatment of Diarrhea in Irritable Colon, Including Preliminary Observations with a New Antidiarrheal Agent, Diphenoxylate Hydrochloride (Lomotil), Amer. J. Gastroent. 35:46-49 (Jan.) 1961.
3. Weingarten, B.; Weiss, J., and Siman, M.: A Clinical Evaluation of a New Antidiarrheal Agent, Amer. J. Gastroent. 35:628-633 (June) 1961.

G. D. SEARLE & CO.

Research in the Service of Medicine

The RHODE ISLAND MEDICAL JOURNAL

VOL. XLV APRIL, 1962 NO. 4

PNEUMATOSIS INTESTINALIS — A MEDICAL AND SURGICAL PROBLEM*

ARSENO C. PASCUAL, M.D.; JOHN R. STUART, M.D., AND WALDO O. HOEY, M.D.

The Authors. *Arseno C. Pascual, M.D., Senior Surgical Resident; John R. Stuart, M.D., Junior Surgeon; Waldo O. Hoey, M.D., Chief of Surgery — all of the Roger Williams General Hospital, Providence, Rhode Island.*

Review of the Literature

PNEUMATOSIS INTESTINALIS, commonly known as gas cysts of the intestines, has also been called pneumatosis cystoides intestinalis, pneumatosis coli and emphysema of the intestines. This disease may be defined as abnormal loculated collections of gas in the wall of the gastrointestinal tract or its supporting structures. The reporting of the first human case is generally attributed to Bang[2] in 1876 although DuVernoi[11] in 1730 and Cloquet[7] in 1820 described this condition. All three of these cases were described at autopsy. Hahn[17] in 1899 was the first to record the disease in a living patient and the first to note the similarity between the disease in man and in swine where it had been recognized in 1825.[29] Finney in 1908 reported the first case in the American literature.[14] Koss in 1952 reviewed one hundred and ninety-four papers describing 255 cases of pneumatosis; of these 213 cases were analyzed.[20]

Since this paper at least fifty-nine more valid cases have been reported.*

Neoplastic[2,14] and bacterial[35,39] theories were initially proposed as the etiology of this disease. However, neither have been substantiated by histologic or bacteriologic study. A chemical theory has also been proposed in part by several authors. Masson thought that gas resulted from chemical action on intestinal chyle.[27] La Mont thought that the gas resulted from a chemical reaction related to the absorption of the contents of a dilated stomach or bowel.[22] More recently Alford has suggested that the pH of the intestinal wall is important in the etiology of pnumatosis.[1] Eveleth proposed a nutritional theory to explain the occurrence of the disease in swine.[12] He was able to reproduce this disease in growing swine by means of a nutritionally deficient diet. The specific nutrient was not identified; but whole corn, unpolished rice, skim milk powder, and yeast were found to contain the antiemphysema factor. Nutritional deficiency may be related to the development of pneumatosis in man, as many of these patients have digestive disturbances and impaired nutrition.[9]

The mechanical theory is now generally accepted as the most plausible etiology. According to this theory intestinal gas penetrates the gastrointestinal mucosa through a defect, either large or small.[20] The gas may then dissect submucosally, subserosally, or into the mesentery.[40] Retroperitoneal dissection may also occur.[44] Increased intraluminal pressure and hyperperistalsis may facilitate the penetration, dissection, and propulsion of the gas.[20,24,44] Many authors have stated that the gas gains entrance into the lymphatic system and that the cysts represent dilated lymphatics.[18,20,27] Histologic study has revealed that many cysts are lined with flattened endothelium, which would support this contention.[20,34] Tung found that serial sections revealed the cysts to be directly connected to the lymphatic system.[45] Gas escaping from a ruptured lymphatic would probably engender a chronic inflammatory response in the adjacent tissues.

Clinical experience has revealed a high incidence of associated peptic ulcer disease which is considered as evidence for the mechanical theory. Lindsay,[24] Mujahed,[34] and Nitch[36] respectively reported that 45 per cent, 50 per cent and over 50 per cent of patients with pneumatosis had peptic ulcer disease. Mujahed found that 75 per cent of his cases were associated with some kind of an intestinal lesion.[34] Turnure reported that 80 per cent of his cases had associated severe gastrointestinal disease.[46] Dale found that the majority of cases of pneumatosis had two common factors present: obstruction of the alimentary tract and mucosal ulceration.[9] Koss reported that 58 per cent of patients with pneumatosis had an associated lesion of

continued on next page

*From the Department of Surgery, Roger Williams General Hospital, Providence, Rhode Island.

*1, 4, 5, 8, 10, 15, 16, 19, 21, 26, 28, 30, 31, 32, 34, 37, 38, 41, 42, 43, 48, 49, 50.

the pyloric area, principally a peptic ulcer.[20] Tung reported an observation which is most interesting.[45] During the course of an operation for pyloric obstruction due to ulcer, gas cysts were noted at the mesenteric border of the small intestine. When the patient who was under spinal anesthesia vomited, the cysts were seen immediately to increase in size. Infants and children with pneumatosis are reported to have a high incidence of associated diarrhea which may be quite severe.[24,25,34]

The respiratory system has been indicted in another mechanism by which pneumatosis intestinalis may be produced. A recent paper by Keyting indicates that pulmonary disease, associated with a harsh cough, alveolar rupture, pneumomediastinum, and retroperitoneal air advancing along vascular routes to the bowel wall may produce pneumatosis.[19] He reported seven cases in which this mechanism was thought to exist in patients who had no gastrointestinal complaints. Doub reported that fifteen out of sixteen patients with pneumatosis sought medical advice initially for asthma or allergic difficulties.[10]

Pneumatosis intestinalis may be asymptomatic and noted first on X-ray examination or at the time of surgery for some unrelated condition. There is evidence that this disease may spontaneously regress and that the numerous cysts may completely disappear. Mori has reported a case wherein extensive cyst formation was found in the small bowel wall during the course of gastric surgery.[33] Nine months later during a laparotomy for intestinal obstruction no trace of the cysts were found. Other cases of spontaneous regression have been reported.[20,37,9,10] Appropriate medical treatment has been recommended for any coexisting disease, while a conservative attitude towards the specific treatment of the pneumatosis has developed.[5,8] Surgical treatment has also been advised for coexisting disease rather than for the pneumatosis.[5] Clinically pneumatosis intestinalis is generally regarded as relatively unimportant in itself.[13]

The cysts of pneumatosis intestinalis may, however, be symptomatic and require surgical treatment. Extensive disease may result in partial or complete intestinal obstruction and resection of the affected intestine may be required.[5,20,30,43,48] Cysts within reach of the sigmoidoscope may be ruptured electrically or mechanically. Obstruction may be caused by narrowing of the bowel lumen by multiple cysts, compression of the intestine by an extrinsic mass, inflammatory adhesions, or volvulus.[2,20,38]

Gastrointestinal bleeding, both persistent and severe, has been reported as a complication of this disease, and in some cases intestinal resection has been necessary to control the bleeding.[1,30,43,25]

One case has been reported wherein intrinsic pressure by the cysts occluded venous channels with subsequent infarction of bowel, perforation and peritonitis.[31]

Submucosal cysts may be the starting point for an intussusception.[6,36] In infants and children submucosal cysts are prone to rupture and become secondarily infected, thus leading to multiple areas of ulceration and possible bacterial colitis.[34] Subserosal cysts may also rupture and cause spontaneous pneumoperitoneum.[5,20,40] In the absence of a perforated viscus this diagnosis should be thought of. Tension pneumoperitoneum has been reported.[47]

A case of pneumatosis intestinalis recently treated by the authors evidenced no coexisting disease to account for the cysts and gave no evidence of spontaneous regression. Surgical intervention required for partial obstruction was followed by an asymptomatic progression of the disease.

Case Report

Case No. 208487. A sixty-six-year-old Greek female admitted to Roger Williams General Hospital with a chief complaint of increasingly severe constipation and abdominal pain of two months duration. The patient stated that she had been constipated all her life and used laxatives regularly. During the past two months the constipation became refractory to laxatives, and enemas were required. Low abdominal and low back pain were experienced during this period; both were relieved by a bowel movement. For two weeks prior to admission a visible, moderately tender left lower quadrant mass was present, which disappeared after an enema and subsequent movement. During the past two years a twenty-pound weight loss had been experienced due to anorexia. There was no history of emesis, diarrhea, melena, or respiratory disease. The patient had resided in this country since 1927. There was no history of parasitic disease while in Greece. The patient had been treated for hypertension for the past ten years. For the past twenty months 500 mg. of chlorothiazide and 4 mg. of Rauwiloid® per day had been taken. Digitalis leaf had also been prescribed. Three years ago a barium enema had been performed and reported to be normal. Physical examination revealed a thin elderly white female in no acute distress. Blood pressure was 200/100, pulse 80 and regular, weight 105 pounds. Pertinent findings were limited to the abdomen. There was a non-fixed, firm, sausage shaped mass in the left lower quadrant which was slightly tender and doughy in consistency. This mass measured 8 x 4 cm. The liver and spleen were not palpable. Bowel sounds were hyperactive but no peristaltic rushes were present. Rectal examination revealed an anterior mass at 10 cm. which was firm in consistency and measured about 5 x 2.5 cm. Studies included a complete blood count and urinalysis, both of which were within normal limits.

An electrocardiogram revealed left ventricular hypertrophy, digitalis effect, and probable coronary insufficiency. The stool was guaiac negative and contained no ova or parasites. The chest X-ray was not remarkable. The patient had been sigmoidoscoped as an outpatient on two occasions. The mass noted on rectal examination was submucosal and nonulcerative. Two biopsies in this area revealed chronic inflammatory tissue with two small areas of foreign body giant cells. A barium enema was interpreted as revealing "extensive disease involving the lower colon—probably neoplastic" (Fig. 1).

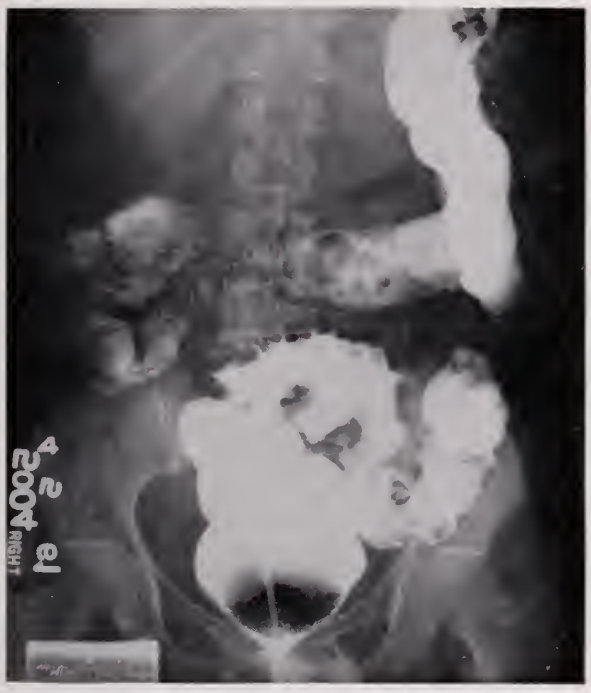


FIGURE I

Laparotomy was recommended and carried out. The palpable left lower quadrant mass was the sigmoid. All layers of the bowel wall from the distal transverse colon to the rectosigmoid junction and probably below the peritoneal reflection were involved with innumerable cysts. The cysts measured from 2 mm. to 3-4 cm. The bowel wall was considerably thickened and distorted by these cysts and had a doughy feeling to palpation. Cysts were also present in the mesentery adjacent to the bowel. There were no retroperitoneal cysts. The remainder of the abdominal exploration was within normal limits. The affected bowel was resected and an end-to-end anastomosis effected above the peritoneal reflection. It was thought that some cysts were left in the distal rectum. The postoperative course was complicated by a severe metabolic alkalosis which responded to additional potassium therapy. The etiology of this imbalance was thought to be a depleted total body potassium secondary to prolonged chlorothiazide therapy.[23] Histologic study revealed that the cysts were located mainly in the submucosa and occasionally in the muscularis and serosa. Cysts were also present in the mesentery adjacent to the bowel in a one to five cm. band. In many areas the cysts were lined by a single layer of flat cells. Elsewhere there was at times no specific lining at all. In many instances granulation tissue with numerous foreign body giant cells comprised the cyst lining. At a five-month follow-up examination the patient was doing very well. There were no complaints referable to the gastrointestinal system and laxatives were not needed. A recent barium enema reveals progression of the disease in the transverse colon (Fig. 2). No cysts were noted in the distal rectum where residual cysts were left at the time of surgery.



FIGURE II

Comment and Summary

This case illustrates that pneumatosis may show no tendency to spontaneous regression and that asymptomatic progression of the disease may occur after surgical treatment. Witkowski has reported a case of pneumatosis which required a sigmoid resection for obstruction.[49] A five-year follow-up revealed X-ray evidence of progression of the pneumatosis to the splenic flexure. This progression was asymptomatic. To our knowledge this is the only other case reported where asymptomatic progression occurred following intestinal resection for obstruction.

It is interesting to note that Koss in 1952 found only thirteen cases of pneumatosis affecting the descending or sigmoid colon in his large series of

continued on next page

collected cases.[20] Apparently the left colon was an unusual location for this disease.[4,20,28,32,38] In the fifty-nine cases known to have been reported since 1952 pneumatosis has affected the left colon in forty-five, a very high percentage. The present case increases the known number reported since 1952 to sixty and those with the left colon affected to forty-seven.

An unexplored possible method of treating the gas cysts consists of oxygen therapy. Analysis of cyst gas has revealed a high percentage of nitrogen, from 70 to 90 per cent. Behnke has shown that over 90 per cent of body nitrogen may be washed out by breathing 95 per cent oxygen for nine hours,[3] and Fine has used oxygen clinically to reduce gaseous distention.[13] If there are no contraindications to oxygen therapy and if the cyst's lining or wall permits gaseous exchange, the absorption of nitrogen should be enhanced and the volume of the cysts reduced.

Finally, pneumatosis intestinalis should not be thought of as a single and unique entity. Interstitial emphysema of the stomach, emphysematous gastritis, pneumatosis vaginae, pneumatosis vesicae, and subcutaneous emphysema are other examples of abnormal collections of gas in the human body.

References

[1]Alford, J. E.; Galleti, G.; and Culver, G. L.: Pneumatosis Cystoides Intestinalis. Am. J. Surg. 92:648, 1956

[2]Bang, P. L. F.: Luftholdige kyster i vaggen af ileum og i nydannot bindevav pa sammes serosa. Nord. med. Ark. 8:1, 1876

[3]Behnke, A. E., and Willmon, T. L.: Physiological Effect of High Altitude. U.S. Nav. M. Bull. 39:163, 1941

[4]Benson, R. E., and Raitt, G. P.: Pneumatosis Cystoides Intestinalis. Ann. Surg. 144:907, 1956

[5]Carter, P. R., and Wilson, H. M.: Pneumatosis Cystoides Intestinalis. Surgery 37:255, 1955

[6]Ciocca.; Atti et mem. Soc. lomb. chir. 1:525, 1933. Cited by Koss[20]

[7]Cloquet, J.: Emphysème du tissue cellulaire qui reunit les tuniques de estomac. Bull. Fac. Med. 8:267, 1820

[8]Creevey, K.; Cohen, J. L.; and Riley, G. J.: Pneumatosis of the Descending Colon. New England J. Med. 259:912, 1958

[9]Dale, W. A., and Pearse, H. E.: Gas Cysts of the Intestines — Report of Two Cases. Surg. Gynec. & Obst. 90:215, 1950

[10]Doub, H. P., and Shea, J. J.: Pneumatosis Cystoides Intestinalis. J.A.M.A. 172:1238, 1960

[11]DuVernoi, G. J.: Aer intestinorum tam sub extima quam intima tunica inclusus: observationes anatomicae. Academiae Scientiarum. 5:213, 1730-1731

[12]Eveleth, D. F., and Biester, H. E.: Further Studies on Intestinal Emphysema of Swine. Am. J. Hyg. 27:364, 1938

[13]Fine, J.; Hermanson, L.; and Frehling, S.: Further Clinical Experiences with 95% Oxygen for the Absorption of Air from the Body Tissues. Ann. Surg. 107:1, 1938

[14]Finney, J. M. T.: Gas Cysts of the Intestines. J.A.M.A. 51:1291, 1908

[15]Glidden, S. A., and Stauffer, H. M.: Pneumatoides Cystoides Intestinalis in Adult: Preoperative Roentgen Diagnosis. Radiology 60:822, 1953

[16]Griffiths, G. J.: Pneumatosis Cystoides Intestinalis. Lancet 2:905, 1955

[17]Hahn, E.: Ueber die Pneumatosis Cystoides Intestinorum Hominis und einem durch laparatomie behandenten fall. Deutsche Med. Wchnschr. 25:657, 1899

[18]Jackson, J. A.: Gas Cysts of the Intestine. Surg. Gynec. & Obst. 71:675, 1940

[19]Keyting, W. S.; McCarver, R. R.; Kovarik, J. L.; and Daywitt, A. L. Pneumatosis Intestinalis: A New Concept. Radiology 76:733, 1961

[20]Koss, L. G.: Abdominal Gas Cysts (Pneumatosis Cystoides Intestinorum Hominis). Arch. Path. 52:523, 1952

[21]Kreeger, N., and Littman, C.: Pneumatosis Cystoides Intestinorum: Report of case confirmed by sigmoidoscopic biopsy. New England J. Med. 251:779, 1954

[22]La Mont, D.: Cystic Pneumatosis of Bowel. Royal Med. Chir. Soc. 23:113, 1928-1929

[23]Leaf, A., and Santos, R. F.: Physiologic Mechanisms in Potassium Deficiency. New England J. Med. 264:335, 1961

[24]Lindsay, J. W.; Rice, E. C., and Selinger, M. A.: Pneumatosis Cystoides Intestinalis in an Infant. Arch. Path. 30:1085, 1940

[25]MacKenzie, E. P.: Pneumatosis Intestinalis: Review of the Literature with Report of 13 Cases. Pediatrics 7:537, 1951

[26]Marshak, R. H.; Blum, S. B., and Eliasoph, J.: Pneumatosis involving left side of Colon. J.A.M.A. 161:1626, 1956

[27]Masson, P.: La Lymphopneumitose Cystique. Ann. Anat. Path. 2:541, 1925

[28]Matthews, F. J. C.: Enteric Pneumatosis. Brit. M. J. 1:851, 1954

[29]Mayer, J., and Hufelands, J.: Prakt. Arzneikunde u. Wundarzneikunde. 61:67, 1825

[30]McGee, A. R.; Penny, S. F., and Williamson, N. L.: Pneumatosis Cystoides Intestinalis with a case report. Radiology 66:88, 1956

[31]McGregor, J. K., and McKinnon, D. A. Jr.: Intestinal Interstitial Emphysema. (Pneumatosis Cystoides Intestinalis) Gastroenterology 35:206, 1958

[32]McKay, E. R.: Pneumatosis Cystoides Intestinalis involving the small bowel and sigmoid colon; Report of two cases. J. Intnat. Coll. Surgeons 23:469, 1955

[33]Mori, M.: Ein fall von Pneumatosis Cystoides Intestinorum Hominus. Deutsche Ztschr. f. Chir. 77:553, 1907

[34]Mujahed, Z., and Evans, J. A.: Gas Cysts of the Intestine (Pneumatosis Intestinalis). Surg. Gynec. & Obst. 107:151, 1957

[35]Naeslund, J.: Zur Kenntnis der Pneumatosis Cystoides Intestinorum: Pathologisch-Anatomische und Experimentelle Studien. Thesis, Upsala. Stockholm, Isaac Markus, 1924

[36]Nitch, C. A. R.: Cystic Pneumatosis of the Intestinal Tract. Brit. J. Surg. 11:714, 1924

[37]Paris, L.: Pneumatosis Cystoides Intestinalis in Infancy. J. Pediat. 46:1, 1955

[38]Rounthwaite, H. L.; Palmer, J. D., and Gardner, C.: Pneumatosis Cystoides Intestinalis. Canad. M.A.J. 73:736, 1955

[39]Sauser-Hall, P.: Pneumatosis Cystoides Intestini. Gastroenterologia, Basel. 65:193 & 313, 1940

[40]Schorr, S.; Ullman, T., and Laufer, S.: Pneumatosis Cystoides Intestinalis. Arch. Int. Med. 88:362, 1951

[41]Sedgwick, C. E., and Ruddell, K. S.: Pneumatosis Cystoides Intestinalis. Lahey. Clin. Bull. 8:238, 1954

[42]Sherwin, B., and Messe, A. A.: Pneumatosis Cystoides Intestinalis. Ann. Surg. 136:893, 1952

[43]Smith, W. G.; Anderson, M. J. Jr., and Pemberton, H. W.: Pneumatosis Cystoides Intestinalis Involving Left Portion of Colon: Report of Four Cases Diagnosed at Sigmoidoscopy. Gastroenterology 35:528, 1958

concluded on page 199

PHEOCHROMOCYTOMA AND HYPERTHYROIDISM

A Case Report

RAYMOND E. MOFFITT, M.D.; DANIEL S. LIANG, M.D.;
FRANK JADOSZ, M.D., AND ADOLFO LIZARRAGA, M.D.

The Authors: *Raymond E. Moffitt, M.D., Internist, Department of Medicine, Our Lady of Fatima Hospital, North Providence; Gastroenterologist, St. Joseph's Hospital, Providence. Daniel S. Liang, M.D., Urologist; Frank Jadosz, M.D., Physician, Department of Medicine; Adolfo Lizarraga, M.D., Former Resident—all of Our Lady of Fatima Hospital, North Providence, Rhode Island.*

PHEOCHROMOCYTOMA is a rare disease; this fact is well known. Approximately 50 cases are reported each year in the United States. However, the association of pheochromocytoma with thyroid disease is exceedingly rare. Two previous cases have been reported, in 1959[1] and 1960,[12] both in the French literature. We shall report a third case.

Case Report

R.R. (O.L.O.F.H. #17792), a thirty-four-year-old white, married female had had four hospitalizations within a year for complaints of nervousness, flushing, headaches, sweating, tremor and generalized weakness of several years' duration. In August of 1960 she was admitted to St. Joseph's Hospital because of "palpitations," a "sick feeling," weakness, and shortness of breath. These symptoms increased in severity during the previous two months and occurred occasionally in a pattern from 10:00 to 12:00 o'clock in the morning and 3:00 to 4:00 o'clock in the afternoon.

Physical examination at that time was negative except for a symmetrically enlarged thyroid gland and some dry wheezing heard over both lungs. A chest X-ray showed pulmonary emphysema. An electrocardiogram was normal. Protein bound iodine (P.B.I.) was 5.7 gamma per cent, iodine (I131) uptake 22.9 per cent. X-ray examination of the stomach revealed a small gastric ulcer along the lesser curvature. The patient was treated conservatively with bed rest and sedation, and discharged after approximately ten days with a diagnosis of hyperthyroidism, pulmonary emphysema, and gastric ulcer.

She was readmitted in acute cardiac failure on October 3, 1960, with presenting symptoms of shortness of breath, fever, and tachycardia. At that time the cause of tachycardia and failure was thought to be a myocarditis of undetermined etiology. The patient was digitalized and given sedation, and finally a trial of corticosteroids with apparent general relief of symptoms over a period of six weeks.

Serial electrocardiograms showed generally a tachycardia with a regular rhythm and nonspecific segment and T-wave changes. Studies of the urine for catecholamines revealed 95 mg./24-hour specimen. Urine 24-hour specimen for serotonin was negative. Routine laboratory studies, blood cultures, febrile agglutinations, viral studies, and phase reactants were normal.

The patient was readmitted to St. Joseph's Hospital on December 22, 1960 with marked hypertension (blood pressure 220/110). This finding had not been noted previously. She was given Serpasil® intramuscularly. The heart rate varied between 120 and 160. Catecholamines were then rechecked and, for the first time, were found to be elevated—first at 813 micrograms per 24-hour specimen and later 1639 micrograms per 24-hour specimen. VMA (vanillin mandelic acid) was strongly positive. P.B.I. was 9.2 gamma per cent; red cell uptake 15.4 per cent. She was discharged on January 7, 1961 with a diagnosis of pheochromocytoma with hyperthyroidism.

Two days later — January 9, 1961 — she was admitted to Our Lady of Fatima Hospital (her fourth hospitalization) for further studies with a view to definitive surgery. Presacral pneumography with carbon dioxide with simultaneous intravenous excretory urogram was done, which revealed both kidneys to be normal in size and position. The calyceal pattern was normal. The CO_2 diffused well on both sides after two injections of 4,000ml. On the right side, medial and superior portions, approximately at the position of the right adrenal gland, a five-centimeter round mass was demonstrated. This was interpreted as an enlarged right adrenal with the possibility that this could be a pheochromocytoma.

The patient was then evaluated by the cardiac team and was prepared for surgery with their surveillance during the procedure. The eleventh rib was removed and the tumor mass, exactly the same size as the X-ray had visualized, was seen at the

continued on next page

medial superior border of the right kidney. At the time of manipulation of the tumor mass, the blood pressure rose to 250 140. Regitine® was given and the blood pressure returned to normal. This was the first opportunity to do a Regitine® test, since the blood pressure had never risen except on this one occasion. After removal of the tumor, the blood pressure dropped to a systolic of 60. Levophed® was given and the blood pressure was controlled.

The postoperative course of this patient was marked by pulmonary emboli which responded to anticoagulants. Tachycardia continued and was controlled by 60 mg. of Tapazole® daily. Cessation of Tapazole during the postoperative period was followed by a return of nervousness and tachycardia of 110-120 per minute. Resumption of this therapy resulted in amelioration of symptoms. On February 10, 1961 she was discharged in good condition. The follow-up of this patient showed that she had made marked improvement, was asymptomatic and doing her own housework—the first time she had been able to do so for several years. The Tapazole was gradually reduced several weeks later, and the patient again noticed slight tremor and slight increased pulse rate. Thus, she was put back on the drug with relief of symptoms and the thyroid gland decreased in size.

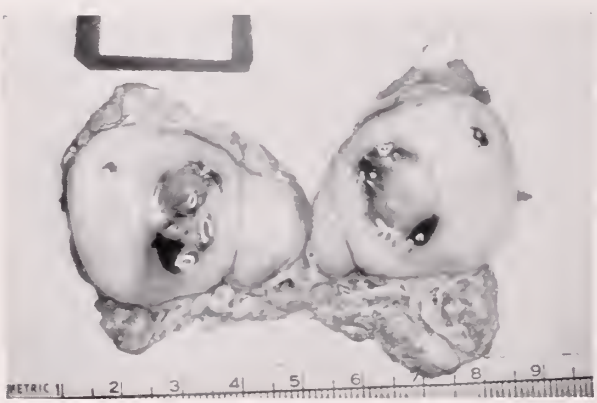


FIGURE 1

Cross section of fresh specimen. See atrophic cortex surrounding the tumor.



FIGURE 2

Positive chromoaffine reaction: cross section of specimen after specific fixation.

Discussion

This case presented a difficult diagnostic problem in view of the lack of presenting symptoms of hypertension and confirmatory evidence of increased catecholamines in the urine at the time of initial examination. In addition, the finding of gastric ulcer did not make us initially suspicious of an adrenal tumor despite the fact that there is a 15 per cent higher incidence of gastric ulcer in this condition than in the general population. The myocardial failure and fever made us suspicious of myocarditis when, in effect, it was actually a high output failure due to pheochromocytoma and hyperthyroidism.

It was not until the patient presented (on the third admission) with hypertension and the confirmatory evidence of VMA and catecholamines in the urine, that the diagnosis of pheochromocytoma was seriously entertained. At that time, every effort was made to locate the tumor. The Regitine® test could not be carried out because hypertension did not return, but attempts were made with adrenal massage to locate the site of the tumor. This did not help in locating the site; but from this point on, there was a continual increase of catecholamines in the urine and a persistently positive VMA test.

It is well recognized that presacral, or renal pneumography is the best means of locating the adrenal tumor. We feel that it is important to repeat the pneumography as many times as indicated as the first films may not be completely satisfactory. In the case in question, after two injections of 4,000 ml. of carbon dioxide, it was not possible to establish clearly that the right side contained the pheochromocytoma. A third attempt, however, revealed its presence.

In this case, bilateral exploration was not necessary because of confirmatory X-ray findings. We were aware that other sites might have been explored, but pending clinical progress, no further surgery seemed indicated. In respect to confirmatory signs of hyperthyroidism, the patient showed an elevated P.B.I. of 9.2 gamma per cent on one occasion. The tremor, enlarged thyroid gland, and response to Tapazole postoperatively (both upon reduction of dosage, in which case hyperthyroidism returned, and increase of dosage, in which case the tremor and tachycardia were controlled), were further evidence. The cases reported by the French authors did not have as many positive features of hyperthyroidism as did this case. At the present time the patient is symptomatically improved and the thyroid gland is much smaller—almost normal in size.

We have found that the most efficient method of handling such problems is by the team approach

—the team consisting of an internist, to act as co-ordinator; a urologist; a cardiac team for monitoring changes during the operation; and a pathologist.

Postoperatively, these patients bear careful watching with vasopressor agents available, with serial determinations of the urine for catecholamines, and with VMA tests. These substances may remain in the urine for several months. This does not necessarily indicate the presence of another tumor. In this case, they persisted in gradually decreasing amounts for approximately four months, eventually returning to normal levels.

Acknowledgment

We wish to thank Salvatore R. Allegra, M.D. for the photography in this case.

BIBLIOGRAPHY

[1]Arnulf, G. H.; Bureau du Colombier, H., and Boussac, J.: Apropos d'un Pheochromocytome Opere et Gueri sans Incident, Lyon chir. 56:301, 1960 (Seance, Nov. 19, 1959)

[2]Labbe, M.; Tinel, J., and Doumer, E.: Un Tumeur Surrenale, Bull. et mem. Soc. med. d. hôp. de Par. 46:982, June 23, 1922

[3]Peigne, F.; Moreau, L.; Tourneur, R.; Bricaire, H., and Gennes, L. de: Pheochromocytomas and Hyperthyroid Manifestations, Ann. endocrinol. 20:654, 1959

[4]Barnett, A. J.; Blacket, R. B.; Depoorter, A. E.; Sanderson, P. H., and Wilson, G. M.: Action of Noradrenaline in Man and its Relation to Phaeochromocytoma and Hypertension, Clin. Sc. 9:151, 1950

[5]Davis, M. C., and Barnett, A. J.: Phaeochromocytoma: Diagnosis and Management, M. J. Australia 46:396, Sept. 15, 1959

[6]Doust, B. C.: Anxiety as a Manifestation of Pheochromocytoma. Report of Two Cases, A.M.A. Arch. Int. Med. 102:811, 1958

[7]Graham, J. B.: Pheochromocytoma and Hypertension; Analysis of 207 Cases, Internat. Abstr. Surg. 92:105, 1951 (in Surg., Gynec. & Obst. February 1951)

[8]Kvale, W. F.; Roth, G. M.; Manger, W. M., and Priestley, J. T.: Present-day Diagnosis and Treatment of Pheochromocytoma; a Review of Fifty-one Cases. J.A.M.A. 164:854, June 22, 1957

[9]Smithwick, R. H.; Greer, W. E. R.; Robertson, C. W., and Wilkins, R. W.: Pheochromocytoma; Discussion of Symptoms, Signs and Procedures of Diagnostic Value, New England J. Med. 242:252, Feb. 16, 1950

[10]Szakacs, J. E., and Cannon, A.: L-Norepinephrine Myocarditis, Am. J. Clin. Path. 30:425, 1958

[11]Watkins, D. B.: Pheochromocytoma: A Review of the Literature, J. Chron. Dis. 6:510, 1957

[12]Bergeron, J.: A Case of Pheochromocytoma, Laval Medical (Québec) 29:178, Feb. 1960

Few can quarrel with the need for medical assistance for the aged, but why discard a plan before it is tried? It should be remembered that Mr. Kennedy, as a Senator, was among those who voted for the Kerr-Mills compromise plan so that he could go to the voters in the presidential election with a record of support.

It would appear that the President's proposal is aimed directly at the votes of the aged with little real regard for the consequences of such legislation.

... Abstracted from an article from the San Diego UNION (Jan. 4, 1962) reprinted in the CONGRESSIONAL RECORD — Appendix (Jan. 10, 1962)

PNEUMATOSIS INTESTINALIS

concluded from page 196

[44]Stiennon, O. A.: Pneumatosis Intestinalis in the Newborn. Am. J. Dis. Child. 81:651, 1951

[45]Tung, P. C., and Ngai, S. K.: Gas Cysts of the Intestines. Chinese M. J. 47:1, 1933

[46]Turnure, P.: Gas Cysts of Intestine. Ann. Surg. 57:811, 1913

[47]Urban, K.: Wien. med. Wchnschr. 60:1750, 1910. Cited by Koss[20]

[48]Villaume, C.: Pneumatosis Cystoides Intestinalis. Nord. Med. 49:912, 1953

[49]Witkowski, L. J.: Pontius, G. V., and Anderson, R. E.: Gas Cysts of the Intestines. Surgery 37:959, 1955

[50]Yunich, A. M., and Fradkin, N. F.: Fatal Sprue (Malabsorption) Syndrome Secondary to Extensive Pneumatosis Cystoides Intestinalis. Gastroenterology 35:212, 1958

IN THE EDITOR'S MAILBOX

To the Editor:

The research library of the Institute of Experimental Medicine and Surgery of the University of Montreal has suffered extensive losses owing to destruction by fire.

In attempting to rebuild our library, we should like to enlist the assistance of the readers of RHODE ISLAND MEDICAL JOURNAL and ask them to send us all available reprints of their work, especially that dealing with ENDOCRINOLOGY AND STRESS.

At the same time we wish to point out that our permanent mailing list was also destroyed; hence we shall be able to send reprints of our own publications only to those of your readers who write for them.

We would be most grateful if you could find some appropriate space in your Journal for the early publication of this request.

Yours sincerely,

HANS SELYE, *Professor and Director,*
Institute of Experimental Medicine
and Surgery, University of Montreal
P.O. Box 6128, Montreal 26, Canada

E. P. ANTHONY, INC.
Druggists
WILBUR E. JOHNSTON, Phar. D.
RAYMOND E. JOHNSTON, B.S.
178 ANGELL STREET
PROVIDENCE, R. I.
GAspee 1-2512
Pharmacy License #225

JUNGLE HOSPITAL

MEYER SAKLAD, M.D.

The Author. *Meyer Saklad, M.D., of Providence, Rhode Island. Former Chief of Anesthesiology, Rhode Island Hospital.*

THE HIGH ANDES of Peru, running from north to south, divide the country into two — a relatively barren area of foothills and coastal plain to the west, and a steaming jungle of tremendous vastness to the east. The western plains and lower regions of the mountains had been the lands of the Inca — an Indian nation of advanced culture and civilization. The Inca, though second to the Mayas in scientific knowledge and writing, were superior in agriculture.

The terrain of the coast and foothills was no great obstacle to Pizzaro and his troops descending from the north, bent on murder and pillage. The proud Inca were massacred, their treasures stolen and their palaces and terraces destroyed. The descendants of this once-proud race, the Quechua Indians, are today a sorry lot. They have but little land, and less dignity. Most serve as laborers and as substitutes for beasts of burden. Too many are addicted to the chewing of coca leaves and drinking the alcoholic beverage, chicha.

The snow-clad mountains, serving as a barrier to the westward flow of water-laden clouds had served also as an insurmountable obstacle to the influences of the outside world upon the Indian in the jungle. In the enormous steaming jungle of eastern Peru live many thousands of Indians. They build their villages along the headwaters of the Amazon and they live by their tribal laws and customs. They depend on fishing and limited agriculture for their food. The Indians living closest to the eastern slope of the mountains are now beginning to feel in full force the inflow of men and ideas from the outside. Those in remote parts will very soon know of the white man, for no longer does the height of the mountains prevent ingress from the world outside. For a long while the Amazon River was the only entrance into the Peruvian jungle — a canoe trip of a few thousand miles from the Atlantic. Recently, missionaries and seekers for oil and riches have crossed the Andes by a winding road through the mountains — a journey of three days to two weeks. Today the airplane is opening the area so rapidly that competing influences, foreign diseases and exploitation are creating havoc and resulting in an unstable and unhealthy physical, moral and political situation.

The white man brings with him his religion and his traits — good and bad. The Indians who are in contact with the white man show evidence of this exposure. The Indians, like Indians in other lands, become second-class citizens. As the white man invades the jungle the Indians lose their lands and fail to obtain title to others. Their agriculture is extremely limited and their diet inadequate. Fishing and hunting is seasonal. Hygiene and housing are poor and proper sewage disposal is negligible. They suffer both the diseases of the jungle and that of the white man. The tropical diseases are many. Amebic and bacterial infection, all types of worm infestation, leishmaniasis, hookworm, kala-azar, malaria, yellow fever, yaws, typhoid and paratyphoid are endemic. The new diseases are tuberculosis, poliomyelitis and diphtheria. The diseases hitherto unknown to them struck a people who, never having had an opportunity to develop a degree of immunity, succumb in vast numbers. The mortality in children to age ten is about 80 per cent. The only medical attention available to the Indians is that of the tribal medicine man. He has a practical knowledge of the treatment of fractures and dislocations and employs herbs which are said to have true pharmaceutical value.

The Indians fear and distrust the white man. As the jungle becomes increasingly "civilized" so does the lot of the Indians worsen. The incidence of disease increases and they face a rapidly deteriorating economic status with loss of their lands and self-government.

To this part of the world and into this extremely difficult and tragic situation a chance for improved health and a better way of living for the Indians was brought by Doctor Theodor Binder. While in practice in Lima, Doctor Binder learned of the sufferings of the Indians and of their great needs. With the advice of Albert Schweitzer, the sacrifice of his life's earnings, and with the help of his wife and friends, both lay and medical, he founded the Hospital Amazonico Albert Schweitzer. This hospital is in the jungle a few miles from Pucallpa. The hospital grounds border the Ucayali River, which

is one of the headwaters of the Amazon. From Pucallpa one may, if one wishes, go by boat from the hospital grounds clear to the Atlantic Ocean.

Mrs. Saklad and I called upon Doctor Binder. I had been asked by the Unitarian Service Committee to determine, if possible, what the future needs of the hospital might be in regard to hospital personnel. It was a two-hour flight from Lima to Pucallpa by way of a non-pressurized plane over the Andes at an altitude of 19,000 feet. It was a one-half hour jeep ride from the landing strip through deeply-rutted, waterlogged roads to the hospital. The hospital is situated so that patients may arrive by road or river. An area in the jungle had been cleared and a 28-bed hospital built. Further ground was cleared for a village for the transient Indians who come to the hospital from great distances. Additional land is now being cleared with the hope that the hospital can be enlarged and that agriculture and animal husbandry could be developed, for the purpose of caring and feeding of patients and for teaching the Indians improved agricultural methods.

The hospital is full and patients are being treated under adverse conditions for, as yet, the hospital has no running water. A dug well supplies the water needs. Fifty-gallon former oil drums are filled and rolled 300 yards to the main building housing patients. There is an adequate power plant, however, and there is a well-equipped X-ray room. The latter does not function since there is no way to develop film because of the lack of running water. The operating room and laboratory have almost no equipment. Through the generosity of medical colleagues throughout the world, gifts from individuals and from organizations as the Unitarian Service Committee, some of the more pressing inadequacies will soon be corrected.

Doctor Binder has a small but loyal staff of four — Doctor Ada Pachas, a young Peruvian female physician; Doctor Binder's wife, Carmen, who serves as laboratory technician and second in command; Mrs. Bertha Zimilef, trained as an engineer, who carries out the clinical supervisory activities and runs the out-patient clinic in the village, and Mrs. Carlota Schulz, who serves many duties as pharmacist, electrical engineer, secretary, driver of the jeep and is in charge of agriculture and of animal husbandry.

In addition to in-patient care, Doctor Binder holds a morning and afternoon out-patient clinic. In the morning the Indians are treated and in the afternoon the Mestizos. It would be wrong to have them both come at the same time because of mutual mistrust and ill feeling. One may see long lines of patients and their families streaming down the narrow road. Fifty to 75 men, women and children are gathered about the hospital entrance. The Indians, many in their native dress, are often overcome by curiosity. They strain on their tiptoes, gazing into the laboratory, the pharmacy and patient rooms. They hold conversation with friends and relatives, the patients and with Indians working in the laboratory. They stare in fascination at the routine of patient care, the drawing of blood, the taking of temperatures and the giving of hypodermic injections.



FIGURE 1
Indian family at village of Paococha receives a bottle of vitamins.



FIGURE 2
Mestizo mother and child waiting to be seen by Doctor Binder.

continued on next page



FIGURE 3

Mestizos from the village of Pucallpa attending out-patient clinic.

As one enters the hospital one is impressed by the enclosed heat aggravated by the many unwashed bodies. The few benches are occupied. The remaining patients and their families are crowded about in the single corridor, leaning against the walls or sitting on the floor. There is a constant hum of excited conversation. Above all this rises the voice of Mrs. Binder, calling for the next patient, and as the patient arises and enters into the makeshift laboratory adjoining Doctor Binder's consulting room, one then senses the initiation of a set and organized and efficient plan for patient care. A brief history is taken, an Indian lad steps up to weigh the patient. A blood sample is taken and routed to a corner in the laboratory. The white count and sedimentation rates are determined and entered on the patient's record, after which the patient is guided into Doctor Binder's office by his wife. The meeting of Doctor Binder and his patient was to me a revelation of the role of Doctor Binder in the jungle Hell. Knowing of the fear and distrust these Indians have of the white man, it was amazing to find the great trust and confidence these Indians have in the people in the hospital in general, and in Doctor Binder in particular. It was but recently that these Indians were hostile to Doctor Binder when he first appeared at their villages.

Doctor Binder speaks quietly to the Indians and to the Mestizos in their own language. He has great tact and gentleness. They submit readily to examination and to treatment. After diagnosis, prescriptions are written and the patient carries these to the small pharmacy to be filled. Here Mrs. Schulz holds sway and the prescription is filled either from the store of samples sent to Doctor Binder from physicians all over the world or from drugs given as gifts. Many of the drugs on the shelves are actually, or soon to be, outdated. Though many drugs are generously donated by drug manufacturers, the supply is irregular and insufficient. There are serious storage problems. Because the heat and humidity cause rapid deterioration of the drugs there is great need for air conditioners and dehumidifiers.

Doctor Binder extends his medical care to beyond the confines of the hospital grounds. As I noted earlier, an out-patient clinic is run in the village of Pucallpa. On occasion Doctor Binder goes to the Indian villages down the river. Here he has met and become friends with some of the medicine men for whom he has great respect and they for him. The medicine men in some of the villages have been taught by Doctor Binder to recognize certain symptoms and to undertake treatment. Doctor Binder feels very strongly that these medicine men have in their own right, expert knowledge in the treatment of certain conditions, and he feels the white man can profit much from such knowledge. Seven Mestizo girls have been trained as nurses and one Indian lad is being taught the fundamentals of hygiene and is being instructed in how to build latrines. This knowledge he will carry back to the villages. A pregnant Indian girl is being brought up in the Binder household. She will learn cleanliness and child care and these she, too, will bring back to her family and friends. The news of the hospital and its people has spread far and wide. Indians come by foot and canoe. Some take as long as three weeks en route. The tribal chiefs have learned to trust Doctor Binder as a friend and they come to him with their problems; problems in regard to living with their neighbors — the white men. Many of these problems are beyond Doctor Binder's ability to handle. They will have to be dealt with on other levels.

A great deal of good is being done at the hospital in spite of the great gaps in equipment and personnel. The breakage of a syringe is a catastrophe, for



FIGURE 4

Mestizo mothers and children waiting to be seen at out-patient clinic.

the total count of syringes was ten. The newborn could not be adequately cared for since there were no baby scales. The material needs are great. They are being listed and attempts are being made to meet them. There is also great need, in addition to materials and equipment, for qualified people. There are pressing needs for a surgeon, laboratory technicians, social workers, etc. Before a surgeon, laboratory technicians and other personnel can be accommodated it is necessary that a building be built to accommodate them. This has a high priority, for until this is done the hospital cannot expand in the proper direction. This, however, awaits adequate funds.

There will be a continued and increasing need for equipment and people because Doctor Binder hopes to enlarge the hospital facilities, and to expand his scope of activities. He believes there is need for a 100-bed general hospital. In addition, he hopes to have a wing for children, one for the care of the elderly and another building for tuberculosis patients. A water tower is being built and its completion in the near future will enable the X-ray department to function. With the completion of the operating room it is hoped that modern medical practice can be brought to this backward area. The addition of a doctor or two will enable better service to be rendered to the outlying communities. The out-patient department in the village can be enlarged. The building where it is held is in need of repair. It is highly desirable to visit ill patients at the Indian villages. If ever a hydroplane can be obtained this can be accomplished.

Paralleling all this is another project. This is an endeavor to improve the nutrition of the Indians. If it is possible to obtain tracts of lands for the Indians, plans are now being made to instruct them in improved farming methods and in the raising of pigs, goats and chickens. Recently many of the tribal chiefs from miles around met in the hospital grounds and were instructed in the construction of latrines. It is Doctor Binder's hope that a social worker team can go to the Indian villages and live with them for some time for the purpose of teaching them hygiene, sewage disposal, the better handling of food and the use of simple mechanical devices as sewing machines.

About 100 miles downriver from the hospital is the Indian village of Paococha, occupied by a tribe of Shipibo Indians. Here was a medicine man who, when Doctor Binder first called upon the village, welcomed him and prevailed upon his villagers to be friendly, for they were at first hostile. He and Doctor Binder had become friends. They work together in the treatment of the ill at the village. Word had come through to the hospital that this medicine man had been taken ill. It was felt desirable to go to his village to determine the cause of his illness, to treat him or to bring him back to the hospital. We had a three-day delay in obtaining the services of a small hydroplane and we then flew down to the village. We landed along the main river, from which it was about one-half hour's trek into the Indian village, which was situated along a tributary too small and unsafe for the hydroplane to land upon. We were fortunate in that we had landed close by some Indians, who came running excitedly over to us at the water's edge and recognized us as coming from the hospital. We were greeted in very friendly fashion. The women were dressed in very colorful costumes, a colorful skirt with a design of geometric pattern, characteristically Shipibo, and a short blouse of red or blue, hanging free. Many had their nostrils and lower lips pierced wtih silver trinkets, and their faces painted in design. The few men we saw wore dungarees. The female children were very prettily dressed. The boys, like their fathers, wore nondescript clothes. All were cheerful and smiling. Some ran off ahead to tell the others of our coming. From the water's edge to the main path was a short but difficult walk. We were helped over puddles and through mud by the Indians. The trek in to the village was long and hot. We were told to stick to the path and of the hazard of poisonous snakes in the deeper grass. Upon arrival at the village we were surprised at its general cleanliness. There was a long series of huts in a straight line paralleling the water's edge. There was an open clearing between this line of houses and the river. This area evidently served as sort of a commons, for along the edge of this clearing were some larger thatch-covered buildings which evidently served as communal structures. We saw no wells and no latrines. Close by the village were some fields in which corn and potatoes were being raised. We saw, however, no pigs, goats or cows. Many of the children gathered around us before one of these communal struc-

concluded on next page



FIGURE 5
Distribution of drugs at Indian village.

tures. Through an Indian lad who served as an interpreter Mrs. Schulz distributed many pounds of vitamins and miscellaneous medicines to the assembled natives. We could see mothers carrying their infants, painted an indigo blue. Many of these infants had their heads covered so they could not breathe too much fresh air for the hazard it would bring. The foreheads of many of them were compressed with boards, so as to flatten the forehead for purposes of beauty.

Upon questioning we learned to our great dismay that the medicine man had not expected us to come for him and had begun the long journey to the hospital by canoe. Word had come through recently to the villagers that because of illness he had to break that journey and was now at some village en route. After having distributed the medicines we returned to the hydroplane and with an Indian lad serving as a guide endeavored to find the village in which the medicine man had stopped. Flying along the tributaries we finally found what we believed was the village, swooped low and some natives waved to us, but we found it impossible to land anywhere near it, so we returned to the hospital without the medicine man. We have since learned that he did indeed get through to the hospital, had become a bed patient, was still there and is now much better.

We had full opportunity to evaluate the need of the Indian in the area of the jungle about Pucallpa and of the people at the hospital who are endeavoring to help them. As to need, the Indian in the vicinity of the hospital is now close to the edge of the jungle. They, like tens of thousands of their kind, are in crying and desperate want. They are being exposed to the outside world with a suddenness for which they are not prepared. The exposure is harmful and dangerous. They need medical aid for their diseases. They need protection from our diseases. They need assistance in integration with the white community and they need protection from the evil-minded amongst us.

No one understands their problems as does Doctor Binder. No group I have ever known works so devotedly, as tirelessly and unselfishly in helping their fellow man as does the group at the hospital. Doctor Binder is a student of tropical medicine. He is skilled in modern medical practice. He recognizes the need for prophylaxis and improved hygiene. He understands also the social and economic problems that face these people. There is so much to do and he has so little. There is want for everything that hospitals require, from safety pins to operating tables, from aspirin to chloromycetin. The jeep, of many years' vintage and the only means of communication to the village for supplies, threatens to breathe its last. Topping the list of priorities, however, is the need for people. A young surgeon or internist, an epidemiologist and social workers could contribute much. Everyone recognizes that the wants will never be fully met. Those working at the hospital and those helping in its support recognize the continued frustration of never being able to fully satisfy the mounting need, for just as rapidly as help comes so will the requirements expand. To Doctor Binder and to those working with him go our appreciation of his task, our understanding of his difficulties, and our thanks to him for being a decent representative of the outside world. Those of us who have the means or the ability to help should assume some of the burden and responsibility.



FIGURES 6, 7 and 8

Hospital trained Mestizo girl preparing to take blood sample from child.

Indian mother and child leaving hospital.

Indian working on pottery at village along Ucayali River.

BRONCHOTOMY FOR OBSTRUCTION OF THE AIRWAY DURING THORACIC SURGERY*

ALBIN N. GRENDA, M.D., AND HAROLD W. HARROWER, M.D.

The Authors: *Albin N. Grenda, M.D., Chief, Thoracic Surgery, Veterans Administration Hospital, Providence, Rhode Island, and Assistant Clinical Professor of Surgery, Boston University School of Medicine, Boston, Massachusetts. Harold W. Harrower, M.D., Chief, Surgical Service, Veterans Administration Hospital, Providence, Rhode Island, and Associate Clinical Professor of Surgery, Boston University School of Medicine, Boston, Massachusetts.*

SUDDEN OBSTRUCTION of the airway during the course of pulmonary surgery is not a frequent complication. When it occurs, relief must be prompt and adequate. Wylie,[6] in an analysis of twenty-one deaths during chest operations, attributed ten to anoxia. Most of the operations consisted of drainage of a lung abscess or empyema. One death was due to emptying of the contents of an abscess cavity into the airway during resection of the right lower lobe. Bosher,[3] in a review of cases of lung abscess treated surgically, reported five instances of asphyxia under anesthesia in drained cases and one during resection. Survival of a patient who sustained massive flooding of the tracheobronchial tree from a carcinomatous abscess while undergoing pneumonectomy is believed to be sufficiently uncommon to warrant recording.

J.H., a forty-four-year-old white man, entered the Veterans Administration Hospital, Providence, Rhode Island with a history of illness beginning five months prior to admission. Symptoms consisted of anorexia, weight loss, productive cough, episodes of fever and night sweats, swelling of the left ankle, and the development of painful, red swellings of surface veins of the lower extremities and right forearm.

The patient was thin and appeared chronically ill. His trachea was deviated to the left and examination of the chest revealed signs of consolidation of the left lung. There were areas of acute and subacute thrombophlebitis of the superficial veins of both lower extremities and the right forearm.

Hemoglobin was 12.7 grams. White blood count was 37,200 with 88 per cent neutrophiles. Chest X-ray studies demonstrated opacification of the left hemothorax with mottled areas of highlighting in the upper half and an air fluid level in the mid-hemothorax. Mediastinal structures were retracted to the left and not visualized. The left main bronchus was visualized in its proximal portion and appeared to end abruptly. The most likely diagnosis was that of endobronchial obstruction with obstructive pneumonia and breakdown on the left (Figure 1). Electrocardiogram was within normal limits. Sputum was negative for acid fast organisms.

Several days after admission, because of extension of the phlebitis in the thighs, both superficial femoral veins were ligated. Inflammation of the veins subsequently subsided. Bronchoscopy showed an obstructing lesion of the left bronchus at the level of the upper lobe takeoff. The tissue biopsy was not definitive, but suggested epidermoid carcinoma. Fever of 100° to 101°F was present during

continued on next page



FIGURE 1
Preoperative chest film.

*From the Surgical Service, Veterans Administration Hospital, Providence, Rhode Island, and the Department of Surgery, Boston University School of Medicine, Boston, Massachusetts.

the first few days of hospitalization. It subsided after a week of therapy with chlortetracycline. Vital capacity (2,000 ml.) and maximum breathing capacity (47 L. per min.) were a little more than half of predicted values.

On June 6, 1960, a left thoracotomy was performed with the patient in the right lateral decubitus position. Anesthesia consisted of endotracheal cyclopropane administration supplemented by a muscle relaxant (succinylcholine). Visceral and parietal pleurae were fused and were separated by blunt dissection. The entire lung had a rubbery consistency and failed to collapse appreciably. The operation which had started at 8:25 A.M. was interrupted at 9:30 by the anesthetist to report a sudden inability to maintain adequate ventilation.

Operative manipulation was stopped. The endotracheal tube was withdrawn a few centimeters and a stream of thick gray fluid gushed forth. Vigorous endotracheal suction failed to improve the exchange. At this point an irregularity of heart action was noted, and the aortic pulsations were markedly diminished, becoming progressively more feeble. The left main bronchus was rapidly freed by finger dissection and a bronchus clamp applied. A 2 centimeter incision was made obliquely on the anterolateral aspect of the bronchus proximal to the clamp and extending into trachea. The tracheobronchial tree was filled with the same viscid material described above and was quickly cleared by direct aspiration. While bronchotomy was being done, the anesthetist succeeded in inserting a second endotracheal tube and giving 100 per cent oxygen under pressure. Improvement in the patient's condition was rapid and dramatic. Cardiac rhythm and vigor returned to normal, and by 9:40 A.M. the anesthetist was again able to ventilate the right lung easily and vital signs were restored to satisfactory levels.

Because of traction on the bronchus clamp and the hurried suctioning out of the trachea and bronchus, the bronchotomy incision had torn upwards a distance of 3 centimeters. Several silk sutures served partially to close the opening as a temporary measure. A second bronchus clamp was applied just proximal to the first, the bronchus severed, and a pack placed against the stump. Some oxygen continued to escape from the tracheal tear above the clamp but did not compromise ventilation. In order to free the chest cavity of the bulk of the lung, resection was completed expeditiously by dividing the pulmonary artery and superior and inferior veins between vascular clamps.

Final closure of these structures was accomplished with arterial silk sutures. Good exposure of distal trachea was then attainable. Swedged on silk (000) sutures were used to close the proximal portion of the tear in the trachea and to effect a plastic repair of the bronchial stump after excising the portion crushed by the blades of the clamp. A pericardial fat pedicle was mobilized after the method of Brewer and sutured over the tracheobronchial repair making it air tight.

During the period of 30 minutes required to complete the pneumonectomy and repair the tracheobronchial stump, the patient's exchange, pulse and blood pressure remained good. Mediastinal node dissection was performed, and a rent in the right mediastinal pleura discovered and closed. A No. 18 Foley catheter was inserted anteriorly and connected to water-seal drainage after closure of the chest incision. The water-seal drainage was a three bottle arrangement, balanced so that a relatively constant minus 5 cm. of intrapleural pressure was maintained. Since the need for mechanical assistance of respiration was anticipated, a tracheotomy was performed before extubation. The tracheotomy tube was connected to a Bird respirator for intermittent positive pressure over a range of 0 to plus 15 cm. of water. Assisted ventilation was maintained with brief interruptions for 48 hours. During this time blood pH ranged from 7.20 to 7.26. A chest film demonstrated the status post pneumonectomy on the left. The lower half of the left hemothorax was irregularly opacified by a pleuritic process. There was a fairly dense pneumonic process in the right cardiophrenic area. The remainder of the right lung was clear (Figure 2). This process cleared by the end of the week.



FIGURE 2

Chest film on second postoperative day showing pneumonic patch at right base.

The report of bronchial culture revealed no growth. Patient remained alert without mental or neurological abnormalities and his recovery was remarkably smooth. The tracheotomy tube was left in place for 14 days. He was discharged fully recovered on his twentieth postoperative day.

Pathology

The specimen was a left lung with a firm indurated surface throughout. In the left main stem bronchus, there was a tumor almost completely occluding it. The margin of the attached portion of the tumor was 2 cm. from the line of excision. The left upper lobe contained an extensive abscess which almost completely replaced the lung parenchyma. The tumor was 4 cm. in greatest diameter. Microscopic sections showed the margin of resection of bronchus free of tumor. Squamous cell carcinoma, quite well differentiated with marked pearl formation, occluded and surrounded the bronchus. In addition, the inner margin of the abscess wall was lined by necrotic tissue and debris.

Discussion

Prompt bronchotomy with direct aspiration of the right bronchus and trachea was the essential maneuver in the salvage of this patient. Persistence in endobronchial aspiration or the delay of bronchoscopy would very likely have resulted in fatal anoxia from incomplete and tardy clearance of the airway via these routes. We know of a recent instance where a portion of tumor, dislodged during the application of a bronchus clamp, obstructed the airway of the dependent lung. Death ensued while bronchoscopic attempts were being made to clear the trachea.

In the case presented the anesthetist's prompt action in inserting a second endotracheal tube alongside the occluded one provided additional oxygenation of the right lung after it had been cleared by bronchotomy aspiration. It has been reported that a patient may breathe through a bronchotomy for short periods without harm, especially with stabilization of the mediastinum.[1,5] In addition, oxygen may be administered into the contralateral bronchus by way of bronchotomy.[4]

Prevention of bronchial spillover can only be obtained with certainty by the use of an endobronchial intubation system which permits selective bronchial occlusion.[2] Use of the prone position, as introduced by Overholt and advocated by Shaw, for tracheobronchial reconstruction would probably reduce the hazards of most degrees of spillage. When spill is massive, as in the patient presented, bronchotomy will still prove to be essential.

SUMMARY

A case of massive flooding of the tracheobronchial tree during pneumonectomy for carcinoma of the left lung is presented. Immediate bronchotomy afforded relief of the airway obstruction with survival of the patient.

We are indebted to James L. Vanderveen, M.D., associate anesthesiologist, Massachusetts Memorial Hospitals, and instructor in anesthesia, Boston University School of Medicine, Boston, Mass., for the anesthetic management of this patient.

References

[1]Abbott, Osler A.: Experiences with the Surgical Resection of the Human Carina, Tracheal Wall and Contralateral Bronchial Wall in Cases of Right Total Pneumonectomy. J. Thoracic Surg. 19:906, 1950

[2]Bjork, Viking O., and Carlens, Eric: The Prevention of Spread During Pulmonary Resection by the Use of a Double Lumen Catheter. J. Thoracic Surg. 20:151, 1950

[3]Bosher, Lewis H.: A Review of Surgically Treated Lung Abscess. J. Thoracic Surg. 22:371, 1951

[4]Goldman, Alfred: Transpleural Bronchotomy. J. Thoracic Surg. 23:237, 1952

[5]Paulson, Donald L., and Shaw, Robert R.: Bronchial Anastomosis and Bronchoplastic Procedures in the Interest of Preservation of Lung Tissue. J. Thoracic Surg. 29:238, 1955

[6]Wylie, R. H., and Kee Jr., J.: An Analysis of the Operating Room Deaths on a Chest Surgical Service. Surg., Gynec. & Obst. 100:42-735, 1955

DID YOU KNOW?

- That at the end of 1961 an estimated 136 million Americans had hospital insurance, an increase of four million over the year before.
- That 124 million persons had surgical insurance, or three million more than at the end of 1960.
- That 91 million persons had regular medical insurance, three-and-one-half million more than in 1960.
- That 35 million persons had major medical insurance, a rise of more than seven million for the largest increase of all health coverages.
- That 43 million persons had loss-of-income insurance, an increase of 600,000.
- That voluntary health insurers paid out an estimated $6.3 billion in benefits during 1961, an 11 per cent increase over 1960.

J. E. BRENNAN & COMPANY

Leo C. Clark, Jr., B.S., Reg. Pharm.

Apothecaries

Two Convenient Locations

5 North Union Street — Pawtucket, R. I.

140 Central Avenue — Seekonk, Mass.

7 Registered Pharmacists

Pharmacy License #226

SOLITARY EOSINOPHILIC GRANULOMA OF BONE IN A SIXTY-SEVEN-YEAR-OLD MALE

STANLEY D. SIMON, M.D., AND CAROLL M. SILVER, M.D.*

The Authors: *Stanley D. Simon, M.D., Surgeon, Department of Orthopedic Surgery, Miriam Hospital, and Assistant Orthopedic Surgeon, Memorial Hospital, Pawtucket. Caroll M. Silver, M.D., Chief, Orthopedic Surgery, Miriam Hospital, and Associate Surgeon, Department of Orthopedic Surgery and Fractures, Rhode Island Hospital.*

THE LESION of the skeletal system known as eosinophilic granuloma of bone became a distinct entity following the work in 1940 of Otani and Ehrlich,[1] Lichtenstein and Jaffe,[2] and Green and Farber[3] in 1942.

Subsequent papers by Jaffe and Lichtenstein,[4] and Ponsetti[5] have stressed the view that eosinophilic granuloma was one clinical manifestation of a basic disorder which included Schüller-Christian Disease and Letterer-Siwe Disease. They considered eosinophilic granuloma of bone, Schüller-Christian Disease, and Letterer-Siwe Disease as different clinical and anatomic expressions of the same basic disorder.

Eosinophilic granuloma of bone represents the mildest and most localized form of the condition. Letterer-Siwe Disease represents the gravest and most generalized expression of the disorder, and Schüller-Christian Disease represents its most chronic manifestation. Ponsetti[5] made a clear distinction between the solitary and multiple forms of the eosinophilic granuloma, stating that in the solitary lesion the prognosis is much better and a cure can be effected by surgery.

Many case reports and review articles have appeared in the literature. The most recent is a review of 50 histologically proved cases studied at Memorial Hospital for Cancer and Allied Disease and the Hospital for Special Surgery which was presented by Sparbaro and Francis.[6] They emphasized that eosinophilic granuloma is usually observed in patients under the age of twenty and most commonly in those under four years of age. It is most prevalent in males. Pain is the outstanding symptom and of relatively short duration, usually one to two months. They found no systemic manifestations in solitary eosinophilic granuloma of bone, and the most common physical finding was a palpable mass. In those under the age of twenty the lesion was found with equal frequency in the long and the flat bones. In those age twenty and over, it is almost exclusively limited to flat bones.

Oberman[7] reviewed forty cases seen at the University of Michigan Medical Center. In this series the oldest case presented was a sixty-eight-year-old male with a proven lesion of a rib. This is the oldest case of eosinophilic granuloma recorded.

The case presented is the second oldest case of proven eosinophilic granuloma.

Case Report

The patient, a sixty-seven-year-old white male physician, stated that on April 12, 1961 he had sudden onset of left chest pain when he reached for a telephone at home and felt a sudden sharp pain in his left rib area. He attempted to continue with his duties as a surgeon but had great difficulty because of the severe pain. Following failure to improve with rest, a rib binder and salicylate analgesia, X-rays of the rib cage and chest were taken on April 18, 1961. Doctor H. P. Lesselbaum reported no evidence of pleural fluid or pulmonary infiltration. The cardiac silhouette was within normal limits in size and shape. The visualized bony thorax with reference to the symptomatic area failed to reveal any evidence of abnormality. Because of the continued pain, several injections of Novocaine® and Hydrocortone® were attempted locally to relieve the symptoms. There was only transitory relief. Routine blood count and urine, blood calcium, phosphorous, and acid and alkaline phosphatase studies were reported as within normal limits. No eosinophilia was reported on routine blood smears. A sputum culture was noncontributory.

A repeat X-ray of the painful area on May 1, 1961, (Fig. 1) "revealed an area of decreased density in the left 5th rib, anterior axillary line. The appearance was not characteristic. Many possibilities must be considered; eosinophilic granuloma, an area of decreased density secondary to local cortisone injection, and an area of local destruction of undetermined etiology are on the list of possibilities." A metastatic series on the following day revealed intact bony structures throughout. Prior

*Orthopedic Service, Miriam Hospital, Providence, R. I.



FIGURE 1

Area of decreased density in the left 5th rib, anterior axillary line.

to surgery it was not possible to palpate any obvious swelling of the rib but the tender area was well localized.

Operation was performed on May 8, 1961. At operation a bulbous thickening was encountered at the curve of the 5th rib. There was marked thickening of the pleura and adherence to the lesion at a site of a pathological fracture. The involved portion of the rib was removed. The pathologic report by Doctor J. Dyckman was reviewed by Doctor Henry L. Jaffe, who concurred in the diagnosis of eosinophilic granuloma of bone (Figs. 2 and 2a).

The post-operative course was uneventful and the patient returned to work in approximately four weeks. A checkup examination on August 3, 1961 revealed no abnormalities of the left rib cage.

The authors wish to point out that though solitary eosinophilic granuloma of bone is essentially a disease of the very young, it may occur in the later decades of life. The response to surgery is excellent.

References

[1]Otani, S., and Ehrlich, J. C.: Solitary Granuloma of Bone Simulating Primary Neoplasm. Amer. J. Path. 16:479, 1940

[2]Lichtenstein, L., and Jaffe, H. L.: Eosinophilic Granuloma of Bone. Amer. J. Path. 16:595, 1940

[3]Green, W. T., and Farber, S.: Eosinophilic or Solitary Granuloma of Bone. J. Bone and Joint Surg. (Amer.) 24—A:499, 1942

[4]Jaffe, H. L., and Lichtenstein, L.: Eosinophilic Granuloma of Bone. Arch. Path. 37:99, 1944

[5]Ponsetti, I.: Bone Lesions in Eosinophilic Granuloma, Hand-Schüller-Christian Disease and Letterer-Siwe Disease. J. Bone and Joint Surg. (Amer.) 30—A:811, 1948

[6]Sparbaro, J. L., Jr., and Francis, K. C.: Eosinophilic Granuloma of Bone, J.A.M.A. 178:706, 1961

[7]Oberman, H. A.: Idiopathic Histiocytosis. Pediatrics 28:307, 1961

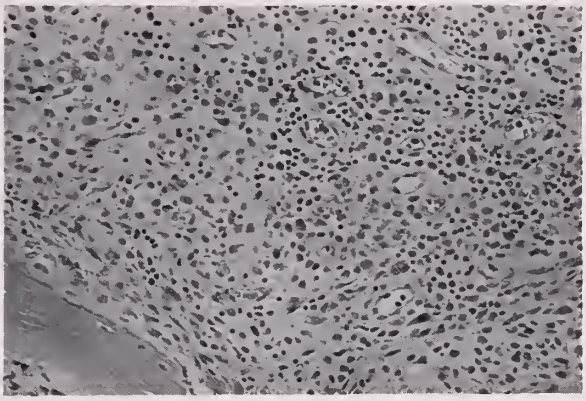


FIGURE 2

Photomicrograph 50x magnification. Bone and vascular connective tissue extensively infiltrated with reticulo-endothelial cells, eosinophiles and lymphocytes.

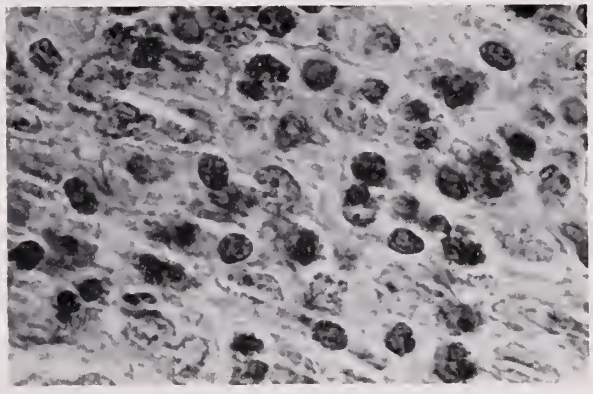


FIGURE 2a

Photomicrograph 2000x magnification. Eosinophiles and reticulo-endothelial cells in center of the lesion.

If each of us could see clearly his self-interest, he would recognize that the socialization of the other fellow's business or industry is also an entering wedge or claim against his own life and liberty and property. The hunger after political power is insatiable, each gulp but an appetizer for the next. And the more government regulates and controls, the more it demands to cover costs and losses. The greater the federal deficits, the more urge to inflate the currency; and the sharper the inflation, the greater the temptation for individuals as well as governments at all levels to invest recklessly in all sorts of uneconomic ventures.

... From NOTES OF THE FOUNDATION FOR ECONOMIC EDUCATION, INC., January, 1962

Patronize Journal Advertisers

MEDICAL MEETINGS AHEAD

Tuesday, May 8 and Wednesday, May 9	R.I. MEDICAL SOCIETY. Annual Meeting. Brown Gymnasium
Wednesday, May 16	7th Annual Postgraduate Conference. Roger Williams Hospital
Wednesday, June 20	Providence Medical Association. Annual Dinner and Golf Tournament. Agawam Hunt Club. Rumford
June 24-28	American Medical Association. Annual Meeting. At Chicago
September 10-13	International College of Surgeons. Waldorf Astoria, New York City
Monday, October 1	Providence Medical Association. Medical Library. 8:30 P.M.
October 1-3	A.M.A. Congress on Industrial Health. Boston
October 10	Pediatrics Symposium, Roger Williams Hospital
October 15-19	American College of Surgeons. Annual Meeting. At Atlantic City
Wednesday, October 31	Annual John F. Kenney Clinic Day, Pawtucket Memorial Hospital
Monday, November 5	Providence Medical Association. Medical Library. 8:30 P.M.
November 6 through November 8	N.E. Postgraduate Assembly. At Boston Statler Hotel

THE TRIUMPH

The hue and cry was over. The well planned attack of organized labor combined with the desire of the politicians to get the "elder citizen" vote had succeeded in socializing another segment of society. A master-stroke had been achieved and the bill had been signed into law by the President. The BARBERS had been socialized. They had argued without avail that the legislation would deprive them of their constitutional rights, that it would result in overusage, that the government could not afford it and that the problem could best be solved by the tried and true system of free private enterprise. But the fight was over. The vanquished returned to work hoping that the effects would not be as bad as they feared. There was one consolation. Wishing to get support from the barbers the statesmen had guaranteed that the price of haircuts would increase from $1.75 to $2.50. That was their consolation prize. Now it was "free" haircuts for all.

The citizens of each community were assigned to a barber and each barber had his list or panel of customers. He was responsible for their tonsorial needs. He was surprised the first morning when he opened the door to find 20 people waiting to get into his shop. Usually no one arrived for at least 30 to 60 minutes. He was further shocked to find folks whose hair had been cut only a few days before. By the time he had finished cutting the hair of the first two townspeople ten more had entered his shop. It was soon obvious that if he were to keep up he would have to cut hair faster. The clipper became the only instrument. Shaping with scissors stopped. The neck shave, the sideburns, and the butch cut were too time consuming to continue. Rapidly the time was trimmed down to three minutes per customer. It was a fast, thrilling race. In the chair (no time for neck-tape), sheet over clothing, clipper racing, sheet off — NEXT. This grueling pace continued day after day. In order to keep up he had to open the shop earlier and close it later. Those who used to have their hair cut every two weeks now came in every four to five days. Anyone with a few minutes off or who wanted to loaf awhile dropped in and had his hair cut.

Anyway it was lucrative — and then the blow fell. The response of the public to this free service was a complete surprise to the governmental officials. Although the same thing had occurred in England a few years earlier, they had refused to believe that it could happen here. The funds simply were not sufficient. Something had to be done. Tht first solution considered was a limit on the number of haircuts per year. The repercussion at the polls would be terrific however, and this scheme died immediately. There was only one answer. The price of haircuts must go down! The barbers let out a roar, but it was drowned out by the editors and the TV current events analysts who pointed out that they were overpaid anyway and had been gouging the public for years and furthermore deserved just what they got. The barber kept trying but his heart wasn't in his work. The quality of even the three-minute haircut worsened. Complaint after complaint was filed by the taxpayers with the barber's political superior. They wanted to change barbers but the panels were all filled. It was him or no one.

The hue and cry is over. The endless lines of people troop in and out of the barber shop but there are no smiles on their faces and their heads show the effect of speed. Their barber isn't smiling either. He is dizzy from the pace, his pride is gone and he looks forward with weary thoughts to the governmental records he must fill out when he finally gets home.

... From the ROCKY MOUNTAIN MEDICAL JOURNAL, June, 1961, as reprinted by the Assoc. of American Physicians and Surgeons

Editorials

THE SESQUICENTENNIAL MEETING

A CELEBRATION always calls for something "extra special."

On May 8 and 9 the Rhode Island Medical Society will celebrate its Sesquicentennial Year with a scientific assembly that is "extra special."

First, the meeting is moved from our own medical library to the spacious Marvel Gymnasium of Brown University. The move will provide larger quarters for exhibits which for the first time will include a dozen or more scientific displays prepared by members of the Society.

Secondly, the meeting will be featured with the presence of a galaxy of outstanding clinicians. In the group will be the most talked of, and about, pediatrician in the world—Doctor Albert B. Sabin whose research work resulted in the development of the oral vaccine for the prevention of poliomyelitis; Doctor Charles Rob, until last year professor of surgery at the University of London, now chairman of the Department of Surgery at the University of Rochester in New York, whose writings on cardiovascular medicine and surgery have been widely read and quoted; Doctor John Howard, co-author of the book SURGICAL DISEASES OF THE PANCREAS, who is currently professor of surgery at Hahnemann Medical College; Doctor Edward R. Annis of Miami, the able and distinguished physician whose television debates on national medical issues with Walter Reuther and various members of the United States Senate have ranked him as one of medicine's ablest spokesmen.

The Society's one hundred and fifty-year celebration will warrant a presentation by historians of the Society on the achievements of the doctors of medicine since the first meeting on September 3, 1812. The close affiliation with Brown University through the years takes on new interest with the report of new plans for medical education at the University. And the Society's prominent role in civic affairs makes the appearance on the program of our distinguished senior United States Senator, John O. Pastore, significant.

From any view the Sesquicentennial Meeting—with its fine lecturers, its scientific exhibits and nearly fifty technical exhibits, its medical motion picture program (another innovation this year)—offers every member of the Society a postgraduate medical assembly of national proportions here in our own state of Rhode Island.

Every member cannot attend every session. But no member should fail to register for some part of the Assembly during its two-day presentation.

THE SURGICAL ASSISTANT

THE AUGUST NEW YORK TIMES recently (Sunday, March 4, 1962) in an article titled *The Doctors Debate Fee-Splitting* has taken cognizance of a rhubarb currently taking place within the medical profession. The term rhubarb meaning an argument or brawl had its humble origin we are told in the Greenpoint Section of Brooklyn, where the kids often got into a scrap before finishing off their daily ration of stewed rhubarb, thus smearing it all over their necks and ears. The current rhubarb over ethics has, we are sure, deep overtones of medical economics. The present disagreement is not concerned directly with uncomplicated splitting of surgical fees as between the surgeon and the referring physician. Since 1903 the A.M.A. has deemed unethical "the giving or receiving of commissions," and considered it "destructive to public good and degrading to the profession." The façade of unbroken opposition to fee-splitting was cracked slightly when the American Medical Association in June, 1961, acted to permit the surgeon to pay the referring physician directly a "reasonable fee" when

continued on next page

the latter acts as an assistant at operation.

The American College of Surgeons, long a bulwark in the campaign against fee-splitting, reached sharply. The results of the College state:

(1) "Ethically, a Fellow may not pay the referring physician for *any* (italics ours) services the latter performs in the care of the patient. . . ."

(2) "A Fellow may not participate in, or countenance, any financial arrangement which would induce referral of a patient. . . ." "This action," stated Loyal Davis, chairman of the Board of Regents of the College, "is regarded as an unfortunate retreat from the American Medical Association's previous staunch declarations against practices which encourage fee-splitting." At the Annual Meeting of Fellows in October of 1961 the College reaffirmed its "proscription of such payment of the referring physician by a Fellow."

The American Medical Association cried out in anguish over what it deplored as a "public airing of disagreements between large segments of medicine." Currently a joint committee of the two potent organizations is attempting to find a satisfactory common ground in the dispute. But it seems unlikely that the College will retreat from its traditional position in this matter.

There are several factors which make this a somewhat more complicated problem than it appears on the surface. In the first place the general practitioners are a much more potent force in the affairs of the A.M.A. than is generally realized.

"The bulk of the A.M.A.," quipped Doctor Paul Hawley, director emeritus of the College, "is made up of referring physicians."

The American Academy of General Practice, 28,000 strong and manifesting an increasingly militant organization, has according to the *Times,* "climbed into the ring," while "some of its top officials assailed the surgeons for having a 'biased and vested point of view and a holier-than-thou attitude.' "

On the surface the following view of the College, recently restated, would seem to be quite without controvery: "To be sure, there are many hospitals without a house staff and without a sufficient number of qualified surgical assistants, in which case it is necessary to use the referring physician as an assistant. . . . In any event, *the referring physician should send his fee for assistantship to the patient directly and should not be paid by the Fellow* (italics ours). . . ." At this point the subtle changes wrought by third-party insuring agencies enter the picture. Most Blue Shield plans do not pay the assisting surgeon and make no provision for his fee. In many such plans the only way he can be paid in the case of service benefit patients, is for the surgeon to pay him out of his own pocket, in other words split the fee. It is quite obvious on reflection that this is the nub of the problem. Since the College admits that there are situations where it is necessary and proper for the referring physician to assist at operations, a dilemma is posed in those cases where no provision is made for his payment, and he may not send a bill.

This problem does not exist in Rhode Island, where the Rhode Island Medical Society Physicians Service follows the enlightened policy of providing payment for the surgical assistant. There is adequate justification in this state, therefore, for all surgical assistants to submit individual bills.

There is another aspect of the problem, however, that calls for some thought. The College further states, regarding surgical assistants: "Assistantship at surgery should be restricted to members of the surgical department or to interns and residents, where they are available . . . in the best interest of the surgical patient and of the education of future surgeons, *the referring physician should not replace a regular surgical assistant or a competent member of the house staff* (italics ours). Outside of the Providence Metropolitan area there are in Rhode Island few house staffs adequate for this purpose and possibly also a dearth of younger trained surgeons to assist at operations. In these farther reaches of the state, it is probably essential that referring physicians or others not surgically trained participate in surgical procedures.

In the Greater Providence area, however, there is a plentiful supply of well-trained young surgeons willing and eager to assist at operations. These men should be used for this purpose certainly in the best interests of the patient and further to encourage them in the pursuit of a difficult discipline. Doctor Robert S. Myers, executive assistant director of the College, has stated the case very well: "The best interests of the patient are served when the surgeon has a regular surgical team which is familiar with his procedures and techniques. This includes a competent surgeon-assistant, and not the casual and untrained assistant." Several hospitals in this area persist, without adequate justification, in permitting, even encouraging, their surgical staffs to employ general practitioners as assistants in the operating room.

We submit that this policy does not conform to the best standards of current surgical practice, and should be discontinued forthwith.

HAVE YOU CHECKED THE DATES?

Sesquicentennial Meeting

at

Brown Gymnasium

MAY 8 and 9, 1962

THE FIFTH BAXTER LECTURE

Those fortunate enough to have heard the Fifth Baxter Lecture, read before the American College of Surgeons in Chicago on October 2, 1961, were well aware that it was an epoch-making pronouncement. This discourse, titled *Volume and Tonicity in Body Water*, delivered by Doctor Francis D. Moore, Moseley Professor of Surgery at the Harvard Medical School, has at last appeared in print in the March, 1962, issue of Surgery, Gynecology & Obstetrics. These new generalizations in the field of homeostasis take their place beside the landmark studies of Walter Cannon and Selye. It will take several readings to grasp the full significance of its sweeping formulations, but there is no doubt that the principles which it enunciates will have an important bearing on human physiology and therapeutics. It is significant that, during the past two decades, surgical research laboratories have been in the van of progress in human homeostatic physiology.

The concepts developed have relation to recent advances in the study of body fluids and the study of that branch of fluid metabolism designated as body composition. It is, the author explains, a progress report on seven years of study of the composition of the body by the multiple simultaneous isotope dilation technique first perfected in 1954 and since then used in some 300 patients. "When the distorting forces of disease or injury," he states, "outstrip the ability of the body to meet them, failure of the maintenance of body composition occurs, and the signs of failure are two. First, are the familiar signs of circulatory failure, loss of intravascular volume regulation, failure of plasma volume support from across the capillary, with oligemia and shock." So much is conventional pathological physiology. He carried this concept one step further, postulating the end-results of this primary failure: "The second signs of failure are energy-linked, and have to do with the body cell mass, especially the function of diaphragm and intercostal muscles. These signs of failure are characteristically seen in chronic disease . . . and acute loss of cellular tissue that results from combinations of severe injury, operation, and pyogenic infections. This failure of the cell mass is finally characterized by inability to obtain or convert the energy cost of breathing and coughing, with a death trap to be found in the lungs. This is failure characterized . . . by bronchopneunomia and sepsis with death due to a failing muscle mass."

The generalizations stated regarding electrolyte, fluid, and red cell mass relationships have a classic and definitive simplicity. The formulas which have been devised are of the simplest algebraic variety. The first formula states a close and constant relationship between the total exchangeable potassium and the intracellular water. The second formulation gives the total body water in terms of the total exchangeable base (i.e., sodium plus potassium). The most important breakthrough in this area, which he attributes to I. S. Edelman, for the first time accurately relates the serum sodium concentration to the total body water and salt (both sodium and potassium). "Edelman's equation," he states, "holds throughout a wide range of human illness and demonstrates that the body is indeed an osmotically homogeneous system and that the concentration of the predominant cation in the extracellular fluid (i.e., sodium) is determined by that of total exchangeable cation in body water (i.e., sodium plus potassium)."

One other new concept is worthy of note. The red cell loss occurring in chronic depletion of tissue, but in the absence of acute or chronic blood loss, is a reflection of reduced need for oxygen carrying capacity, rather than a metabolic failure. "The red cell volume is tailored to fit the cell mass that it supplies and the plasma volume is directly supported and quantitatively related to the size of the extracellular fluid. The blood volume, therefore, represents a miniature peripheral reflection of the relationship between the body cell mass and its supporting tissues." The need for blood transfusion in debilitated patients must therefore in the future be reconsidered in the light of this new concept. "Hemorrhage and transfusion" he says, "are superimposed on this background."

Students of surgery, medicine, and physiology will do well to study and restudy this complex but important paper. We can give here but a sampling of the concepts into which it delves. A few of the author's conclusions, however, are worth restating:

"The body composition may be described in terms of the total exchangeable base and the total body water."

"Both volume and concentration are determined by the interrelations of a simple system."

"The two predominant cations of this system—sodium and potassium—epitomize respectively the extracellular tissues (ECT) and the body cell mass (BCM)."

"The body cell mass provides a basis for expression not only of energy exchange but also of its oxygen-supplying component, the red cell volume."

"While the treatment of circulatory failure is well developed, the treatment of this failure to meet the energy cost of breathing and coughing is still in its infancy. . . . As the body cell mass fails to meet the energy costs of breathing and coughing, respiratory insufficiency and pulmonary sepsis result."

"The maintenance or resumption of normal volume and tonicity in the ratio $Na_e + K_e/TBW$ (i.e., total exchangeable sodium plus potassium to total body water) is essential to survival."

THE MEDICAL EDUCATION LOAN GUARANTEE PROGRAM OF THE AMERICAN MEDICAL ASSOCIATION

MEDICAL STUDENTS, interns and residents have a new financial support available to them. A loan plan which has been under consideration within the American Medical Association for a number of months has now been accepted by the Board of Directors of the American Medical Association Education and Research Foundation as one of the programs of the Foundation.

ELIGIBILITY FOR PARTICIPATION. This loan plan will assist students who need financial help at any stage of their medical education. Unlike many other loan programs, first-year medical students will be able to secure aid. In fact, it is hoped that the existence of this loan program will provide premedical college students a sound basis for planning the financing of a substantial portion of the cost of their medical education. It is also expected that availability of these funds will assist interns and residents in selecting their training opportunity. Loans will be available to full-time students in good academic standing who are U.S. citizens. Medical students must attend one of the American medical schools approved by the Council on Medical Education and Hospitals of the American Medical Association. Interns and residents are eligible if they take their training in a hospital approved by the Council.

OPERATION OF THE PROGRAM. In general, the program will be similar at all levels of medical education, both graduate and undergraduate. In order that the plan operate effectively, medical schools, the banking industry and the AMA will each play a unique but significant role. Medical schools will make the details of this plan known to the students and provide application materials to students who need to borrow. Private banking institutions will make the loans and the AMA-ERF will guarantee the loan so that the interest cost to the student will be minimized.

Medical schools are in the best position to counsel with students concerning their financial problems and to provide them with helpful information. In the case of interns and residents, similar information will be available from the Chief of Service or Program Director of each approved hospital.

Loans will be made through a combine of large banks, who will pool financial resources out of which the loans will be made. All processing and records administration will be provided by the Continental Illinois National Bank and Trust Company, so that the greatest possible savings can be realized through volume and mechanization. As a direct result of this streamlining, the cost to borrowers in the present money market will be reduced to 5½ per cent simple interest during their training period.

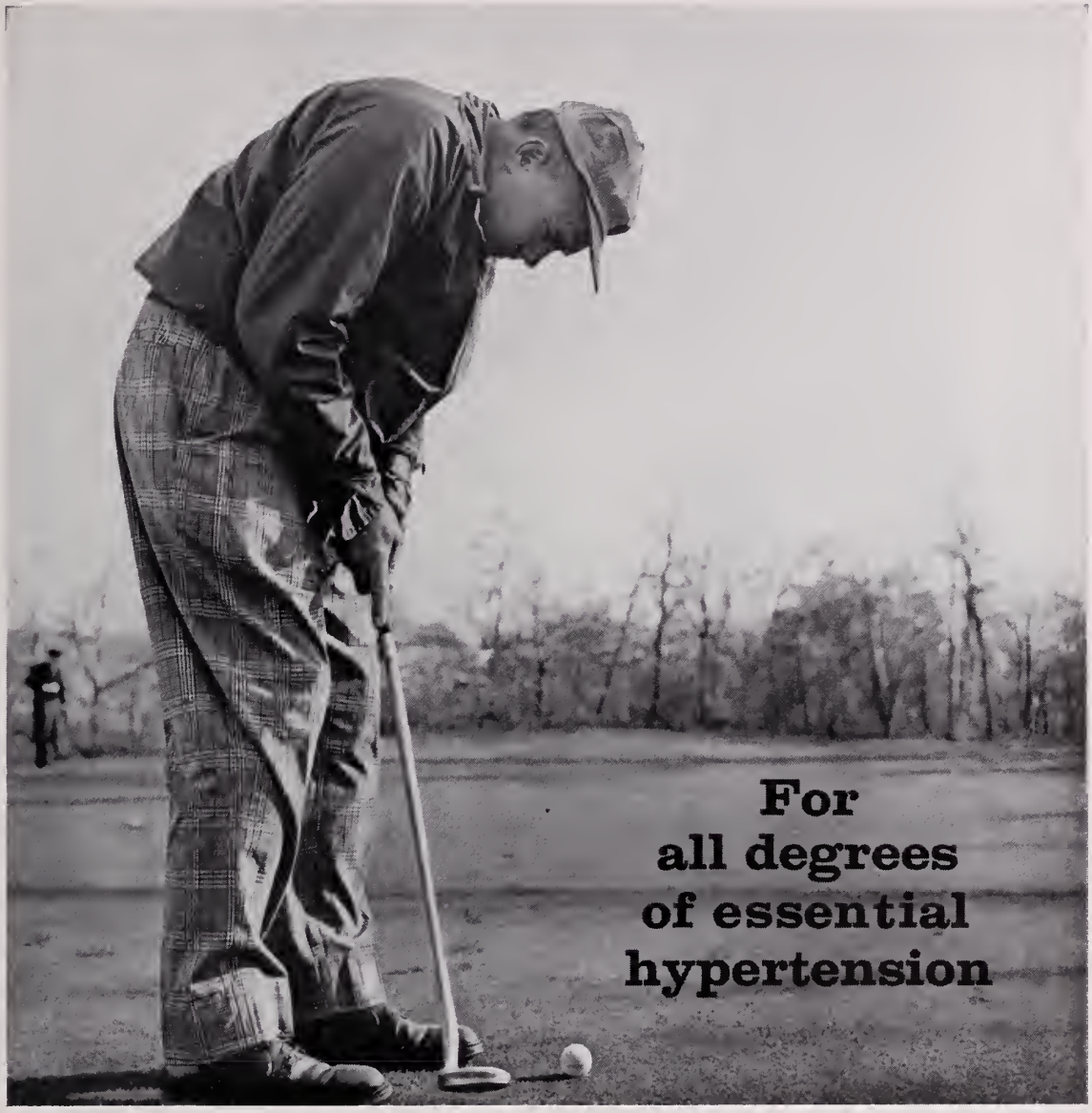
The AMA-ERF will serve several functions. First, AMA-ERF will act as guarantor for all borrowers and will maintain the security fund to guarantee lenders against defaults. AMA-ERF will also be responsible for raising sufficient capital for the guarantee fund to meet the demand for loans. Finally, AMA-ERF will provide certain administrative facilities necessary to the operation of the program.

LIMITS OF THE PROGRAM. With respect to the total program, it is necessary for the AMA-ERF to maintain a loan security or guarantee fund equal to at least 8 per cent of all notes co-signed. In other words, to loan a total of $12,500,000 to medical students, $1,000,000 must be maintained in a guarantee fund. The purpose of this fund is to insure to each participating bank funds available to pay off any notes that are defaulted.

With respect to borrowers, the loan limit is $1500 in any one twelve-month period and $10,000 total within a seven-year period. A further limitation is that the total of all accumulated loans for educational purposes may not exceed $15,000.

COST OF THE PROGRAM. Program cost will be contained in three items: administrative expenses, losses through defaults and interest charges. The first will be an expense of the AMA-ERF, the second charged to the security fund, while the latter will be an expense to the borrower. Interest costs will vary with the individual loan but the current agreement with banks specifies that the interest rate cannot be more than 5½ per cent simple during the training period. Thus if a first-year medical student arranged for a loan of $1,000 at the maximum 5½ per cent rate and expected to enter a two-year residency program after medical school and internship, he would sign a note for $1408 which would fall due seven years and five months after the loan was made. The five-month

continued on page 216



"relief of symptoms is striking with Rautrax-N"†

Rautrax-N decreases blood pressure for almost all patients with mild, moderate or severe essential hypertension. Rautrax-N also offers a new sense of relaxation and well-being in hypertension complicated by anxiety and tension. And in essential hypertension with edema and/or congestive heart failure, Rautrax-N achieves diuresis of sodium and chloride with minimal effects on potassium and other electrolytes.

Rautrax-N combines Raudixin (antihypertensive-tranquilizer) with Naturetin c̄ K (antihypertensive-diuretic) for greater antihypertensive effect and greater effectiveness in relief of hypertensive symptoms than produced by either component alone. Rautrax-N is also flexible (may be prescribed in place of Raudixin or Naturetin c̄ K) and economical (only 1 or 2 tablets for maintenance in most patients).

Supply: Rautrax-N — capsule-shaped tablets providing 50 mg. Raudixin, 4 mg. Naturetin and 400 mg. potassium chloride. *Rautrax-N Modified* — capsule-shaped tablets providing 50 mg. Raudixin, 2 mg. Naturetin and 400 mg. potassium chloride.

†Hutchison J. C.: Current Therap. Res. *2*:487 (Oct.) 1960.

For full information, see your Squibb Product Reference or Product Brief.

Rautrax-N*

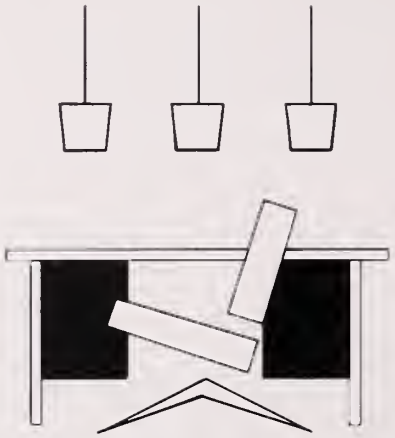
Squibb Standardized Rauwolfia Serpentina Whole Root (Raudixin) and Bendroflumethiazide (*Naturetin) with Potassium Chloride

SQUIBB *Squibb Quality — the Priceless Ingredient*

SQUIBB DIVISION Olin

'RAUDIXIN'®, 'RAUTRAX'®, AND' NATURETIN'® ARE SQUIBB TRADEMARKS.

Attractive & Functional Offices
by BENÉ & CO., INC.



Designers & Suppliers of Offices
150 Dorrance Street • Providence 3, R. I. • GAspee 1-5228

LIFE INSURANCE or DEATH INSURANCE?

SOME Medical men need DEATH Insurance ONLY.

Others need accumulating, guaranteed dollar values to meet their LIVING needs in the future — DEPRESSION — EMERGENCY — RETIREMENT, etc.

In any event, our new "CHEAPER-THAN-TERM" DEATH INSURANCE is the first step in the right direction!

Don't make any important changes in your Life Insurance or Estate plans without investigating "CHEAPER-THAN-TERM"!

For further information about this sensational new development in DEATH INSURANCE, write or phone:

ROLAND A. DEROSIER
32 Custom House Street
Providence 3, Rhode Island
GA 1-1391

MEDICAL EDUCATION LOANS

continued from page 214

period is intended to provide time for the physician to relocate after completion of residency. It should be noted that although no payments of principal or interest are made while the student is in training, no charge is made by the bank for carrying the interest that accumulates. This lack of compounding results in a saving of $81 for the borrower in the example given above.

REPAYMENT. A new note will be executed each time additional loan funds are granted to a borrower. This note, known as an "interim note" will include the principal and interest from the previous note and the principal and interest for the new loan to be granted. Five months after the borrower completes his training he has the privilege of converting the interim note into a payout note with a specified monthly payment schedule. The payout note will bear interest, in the current market, not to exceed a 3½ per cent add-on rate. If the accumulated amount to be repaid is less than $7200, the borrower may choose a level monthly payment of $30 a month or more. In the case that a greater amount is to be repaid, he may choose a repayment schedule which will provide a ten-year period with small payments (5 per cent of the total annually) for each of the first three years, moderate payments (10 per cent of the total annually) for each of the next five years, 15 per cent of the total amount during the ninth year and the remaining 20 per cent during the tenth year. This plan permits the debt to be retired during the physician's first ten years in practice. The borrower has the further privilege of prepaying the loan thus reducing the interest costs.

Another option for the borrower is that he may choose to transfer his loan from the Continental bank to a local bank in the community where he establishes his practice.

EXAMPLES OF LOAN GUARANTEE PLANS. Student loan guarantee funds are now operating in a number of states. Massachusetts established the first such program in 1956 and now has endorsed loans for residents of that state amounting to more than five million dollars. New York State has chosen to subsidize educational loans both while the student is in school and during the repayment period. New York loan volume has now reached almost twenty million dollars. At least six other states have loan guarantee plans in operation.

In the past several months, more than 1400 educational loans have been made to students in Indiana of which almost 100 have been loans to students in medical school. These loans have been made by Indiana banks with the Indiana Higher Education Plan acting as guarantor. Assisting with the operation of the Indiana plan, as is also true in

other states, is United Student Aid Funds, Inc. United Student Aid Funds is a private, non-profit corporation designed to endorse low-cost loans made by local banks to needy college students. Its goal is to make it possible for any needy student in the nation to borrow money at his neighborhood bank without tax subsidy of any kind. The Medical Education Loan Guarantee Plan has been developed with the counsel and assistance of USAF.

ADVANTAGES OF THE PLAN. The AMA-ERF Loan Plan provides a number of advantages:

First: It creates the opportunity to borrow up to approximately one-half the cost of a medical education for any student in good standing. The total number of students who can be assisted is limited only by the size of the security fund. Thus, this plan can make a major attack on the problem of financing a medical education.

Second: It assists financing of medical education without subsidy of any kind.

Third: It provides loans at a low cost.

Fourth: The length of time over which the student in medical education can borrow is designed to fit the period of time required to complete his educational plans. Furthermore, the repayment may be spread over a ten-year period so that the installments are of a reasonable size even for a maximum size loan.

Fifth: Contributions to the security fund multiply to provide 12½ times their amount in student credit.

FUTURE GROWTH. It is difficult to predict the size the new loan program of the AMA-ERF may ultimately reach. Approximately 55,000 students and physicians are currently enrolled in all phases of full-time medical education. If as few as 10 per cent were to borrow an average of $1,000 annually from the AMA-ERF Loan Program, this would require 5½ million dollars in credit and a security fund of $440,000 each year. At that borrowing rate and estimating an average of ten years encumbrance on the security fund, $4,440,000 would be required to make the fund self-perpetuating. Borrowing by a greater percentage of medical students would, of course, impose need for a proportionally greater security fund.

A TYPICAL EXAMPLE. As a medical student Bob S. finds an annual deficit of $1,000 between the cost of medical school and his available resources. Assuming that this condition prevails over the medical school years and an increase in family raises the deficit to $1,500 a year during internship and a two-year residency, the following tabulation is a record of his loans:

Date of Loan	Amount Borrowed	Maturity Date
9/62	$1,000	11/69
9/63	1,000	11/69
9/64	1,000	11/69
9/65	1,000	11/69
9/66	1,500	11/69
9/67	1,500	11/69
9/68	1,500	11/69
	$8,500	

On or before November 1, 1969, Bob converts the interim notes to a payout note with equal monthly installments over the maximum ten-year period. Therefore 3½% of the amount owed the bank is added for each year the payout note is to run. Thus 35% or $3,599.03 is added for interest charges. Finally the monthly payment is determined by dividing the total principal and interest by 120 months or $13,881.96 ÷ 120 = $115.68 per month.

This example, in the interest of clarity, has avoided any complication of change of interest rate, or unequal installments in the payout period. The unequal installment plan might have been chosen by Bob which would have reduced his monthly payments by approximately one-half during the first three years while increasing them during the final twenty-four months. The total interest charges would be slightly higher, however, as Bob would have the use of the money he borrowed over a longer period of time. In this example, Bob has borrowed $8,500 during a seven-year training period. Upon completion of training and shortly after entering practice, Bob begins a series of monthly payments of $115.68 which will continue for ten years.

Term of Note	Amount of Interest (5½%)	Maturity Value of Note
7 yr 2 mo	$ 394.17	$1,394.17
6 yr 2 mo	339.17	1,339.17
5 yr 2 mo	284.17	1,284.17
4 yr 2 mo	229.17	1,229.17
3 yr 2 mo	261.25	1,761.25
2 yr 2 mo	178.75	1,678.75
1 yr 2 mo	96.25	1,596.25
	Accrued Interest $1,782.93	$10,282.93

DID YOU KNOW?

- **That the common cold causes an estimated annual loss to the nation's economy of more than $3 billion.**
- **That the common cold is responsible for an estimated 83 per cent of all illnesses between birth and age 18.**
- **That the common cold causes more than 20 million illnesses per year in the preschool age group alone.**

DISTRICT MEDICAL SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

The annual meeting and election of officers for 1962 was held on January 31, 1962 at the Hotel Viking, with José Ramos, M.D., presiding.

No minutes were available for the last meeting.

Committee reports: Doctor Donald Fletcher, chairman of the Executive Committee had nothing to report. Doctor John Malone, councilor to State Medical Society had nothing to report. Doctor Philomen Ciarla, delegate to the House of Delegates had essentially nothing to report.

Doctor Samuel Adelson outlined the history of the development of the political information committee and urged members of the society to take whatever action we can to defeat the King-Anderson bill and to contact their congressional delegates relative to their feelings on Social Security coverage for medical care for the aged.

Doctor Adelson discussed bills currently before the state legislature regarding health matters and spoke at length on the bill to amend the laws relating to the Blue Cross and Physicians Service plans and the movement under way to appoint a public majority to the Board of Directors of both plans. He pointed out that no insurance company can sell our services and that if the bills pass a large majority of Physicians Service members will resign leaving the plan as only another insurance company. He invited and urged all members to appear at the public legislative hearings at the State House regarding this bill on February 2, 1962. He also reported that the Bristol and Kent County Medical societies voted unanimously to resign as participating physicians in the Physicians Service plan if the proposed bills become law.

Rhode Island---Psychiatric Residencies

2-year approved active training program. Somatic therapies, psychotherapy, individual groups. Individual supervision by Diplomates of American Board. Child psychiatry affiliation. $5,750 yearly, maintenance. E.C.F.M.G. certification required. Superintendent, State Hospital, Howard, Rhode Island.

Doctor Serbst also discussed the law recently passed by the General Assembly and signed by Governor Notte to include chiropodists under the Physicians Service plan. It was estimated that the cost of chiropodists' services would approximate $150,000.00 per year. Doctor Serbst also moved that a letter be sent to Senators Pell and Pastore and Representatives St. Germain and Fogarty inviting them to meet on a weekend in the near future with the Newport County Medical Society so that we can discuss our strong stand against the King-Anderson bill. In discussion of this motion, Doctor Adelson urged that meetings with state and federal legislators and any action taken by the local or state societies relative to the House Resolution 13 or the King-Anderson bill be made public since we feel so strongly that both of these bills are contrary to the public interest and welfare.

Doctor Frank Logler reported on recent meetings of the Physicians Service Board of Directors and recent changes in the by-laws of the Physicians Service Corporation returning more authority from the Board of Directors to the full corporation of the Physicians Service.

Doctor Logler urged that the State Medical Society organize a Rhode Island Medical Public Action Committee (RIMPAC) to inform the public of the society's position on matters relating to the public health. He moved that such a committee be formed and provided with an Executive Director supported by assessment on the membership, to present forcefully and in a militant manner, the society's feelings regarding present and future legislation relating to health matters and to take our position to the people at election time. This resolution was unanimously adopted.

Doctor Serbst moved and it was unanimously voted that if House Resolution 13 which provides for a majority of non-physicians on the Board of Directors of the Physicians Service Corporation becomes law the members of the Newport County Medical Society resign as participating physicians from the plan.

Doctor Serbst moved that the Newport County Medical Society be assessed an undetermined amount to purchase ads in the Newport Daily News to inform the people of the county of the free services rendered by local physicians and the time donated in the care of indigent and emergency room patients.

This motion was amended by Doctor Logler to the effect that the society sponsor such a program by a deficit assessment as the Newport School Committee does.

It was further amended by Doctor James Callahan that Doctor Serbst be empowered to draw up a program to inform the people and report back to the full medical society at a special meeting to be held in the near future.

The motion was further amended by Doctor Adelson that a resolution empowering Doctor Serbst to proceed and submit an ad for approval to the officers of the society and then to have such ad published in local news media.

Doctor Serbst moved and it was unanimously voted that the public be informed of our unanimous vote to resign as participating physicians from the Physicians Service plan if House Resolution 13 becomes law. It was also moved and voted unanimously that the public be informed of our invitation to our congressional delegates to discuss the King-Anderson bill with us.

It was also moved and unanimously voted that the public be informed of the Newport County Medical Society's recommendation to the Rhode Island Medical Society that a medical-political action committee be formed.

Officers elected for the ensuing year were:

President ..... DONALD B. FLETCHER, M.D.
1st Vice-President ..... CHARLES A. SERBST, M.D.
2d Vice-President ..... FRANK LOGLER, M.D.
Secretary ..... RICHARD R. KNOWLES, M.D.
Treasurer ..... JANIS GAILITIS, M.D.
Delegates to the State Medical Society
PHILOMEN P. CIARLA, M.D.,
CHARLES DOTTERER, M.D.
Councilor to the State Medical Society
JOHN MALONE, M.D.
Censors ..... SAMUEL ADELSON, M.D.,
JAMES CALLAHAN, M.D.

The meeting adjourned at 10:15 P.M.

RICHARD R. KNOWLES, M.D., *Secretary*

FOR SALE --- $400 complete

PROFEXRAY— combination fluoroscope and X-ray machine. New tube never been used, In good condition. 20 ma. This price includes the machine, wall bracket for chest plates, tank for developing, lead apron and lead gloves, and all miscellaneous equipment, but not cost of moving. May be seen at Dr. M. J. O'Brien, 40 Elam St., N. Kingstown, CYpress 4-3831.



On Her Birthday...

There'll be stars in her eyes . . when you wrap her in an irresistible Harris Mink scarf, stole, jacket or coat!

WILLIAM H. Harris

New England's Largest Exclusive Furrier
400 Westminster Street
One-Half Century of Fine Fur Tradition



Fuller

Memorial Sanitarium

Located on Rt. 1

South Attleboro, Massachusetts

A modern non-profit hospital for the care and treatment of nervous and emotional disorders as well as long term geriatric problems.

Physical, neurological, psychiatric and psychological examinations.

Modern recognized psychiatric therapies.

A pleasant homelike atmosphere in a beautiful and conveniently located institution.

L. A. Senseman, M.D., F.A.P.A., Medical Director
Edwin Dunlop, M.D. Michael G. Touloumtzis, M.A.
Oliver S. Lindberg, M.D. William H. Dunn, M.S.W.
W. H. Lesovsky, M.D., Ph.D.

Referred patients are seen daily (except Saturdays) 9-12 A.M., and by appointment.
R. I. Blue Cross Benefits Tel. Southgate 1-8500

Special Rates for Long-Term Care

H.R. 4222: COMPULSORY HEALTH TAXATION

Extension of Remarks

OF

HON. STEVEN B. DEROUNIAN, *of New York*

IN THE HOUSE OF REPRESENTATIVES

Wednesday, March 21, 1962

(Reprinted from the CONGRESSIONAL RECORD of March 21, 1962)

MR. DEROUNIAN: Mr. Speaker, so much misinformation is being fed the American people on what H.R. 4222 will do that it is about time the record was set straight.

When Walter Reuther appeared before the Committee on Ways and Means, last year, testifying on H.R. 4222, he stated that although this bill was not all he wanted, it was "a good beginning" and should be expanded. One need not have a crystal ball to see what will be coming next.

The March 1962 issue of Nation's Business has an excellent editorial on the subject and also a fine title for H.R. 4222:

Compulsory Health Taxation

Before this session ends Congress will undoubtedly have before it a proposal to strengthen Federal drug inspection and standards. The purpose is to protect the consumer from unsafe products, misleading labels, and the sale of habit-forming drugs.

Already before Congress is a bill which would require working people to buy something officially called health insurance for the aged, to be marketed by Social Security.

Congress can demonstrate its interest in consumers by applying to this political potion the sort of tests proposed for drugs.

It will find, to begin with, that it is flagrantly mislabeled.

This mandatory health concoction is certainly not insurance. Those who hope to benefit from it will have no assurance of anything except this Congress' willingness to pass a law. No contract protects them if some future Congress decides to change eligibility rules, alter the benefits, increase the costs or discontinue the plan altogether. Future benefits depend on workers' and employers' willingness to pay social security taxes already scheduled to increase 54 percent by 1968. The new plan would add to that burden.

As for the potion itself, several important ingredients of an effective health plan are lacking. The beneficiary would still pay for physicians' calls at home, office, or in the hospital; for surgery; for dental care; for medicine except when administered in a hospital or nursing home.

Even the ingredients included are watered down. Although social security would supposedly pay for 90 days stay in the hospital, the patient would pay $10 a day for the first 9 days.

The term "aged" is also misleading. No one not under social security or Railroad Retirement is eligible. Nor are those however needy who are less than 65 years old.

As for the habit-forming dangers of this prescription, its friends not only admit them, they boast of them. Former Congressman Aimé Forand, of Rhode Island, who offered the first such measure, has said: "If we can only break through and get our foot inside the door, then we can expand the program after that."

At a time when a half dozen Government agencies are boasting of their efforts to enforce fair competition, one of them might reasonably insist that a Government scheme offered in a field where private companies are selling good insurance tailored to buyers' needs should be labeled for what it is:

Compulsory health taxation.

Mr. Speaker, in last Sunday's New York Herald Tribune, Raymond Moley details some of the results of the King-Anderson bill, if passed. It is most revealing that when he spoke to Aneurin Bevan, the British Socialist, on how he expected to control the British medical profession, Bevan's reply was:

We have got the hospitals, and that means we will control the doctors. They cannot practice without places to practice.

The Department of Health, Education, and Welfare, under the Kennedy bill, will lay down rules and regulations for hospitals. Need I say more? Mr. Moley's article is as follows:

The Control of Hospitals
(by Raymond Moley)

On a dark, rainy night in February 1950, in Bristol, England, I had a most interesting evening with the Socialist firebrand, Aneurin Bevan. It was during the national election which all but shook the

Labor Party from power. Bevan was Minister of Health, in charge of the new national health service.

Along with two other American newspapermen, I met Bevan at his hotel before a political meeting which he was to address and arranged to see him when he returned. We were very anxious to question him about his favorite subject, the national health service.

The meeting which we attended was a very rowdy affair. A tough dockworker in the front of the audience was engaged in a running fire of mutual recrimination with the sturdy speaker. In the course of their exchanges the heckler drew from his mouth a plate of false teeth and waved it at Bevan, who shouted, "I am the Minister of Health and I am going to take those teeth away from you." The man shouted back, "I paid 5 pounds for these and they are my own."

The argument ceased, and Bevan put on display as forceful a demonstration of crowd control and incitement as any demagog I have ever been privileged to hear.

After the meeting we met in the restaurant of the hotel and engaged in 3 hours of discussion of issues. The best remembered comment was his reply to my question about how he intended to get control of the British medical profession. His reply was, "We have got the hospitals, and that means we will control the doctors. They can't practice without places to practice."

This comment came back to me as I read the President's message, delivered 2 weeks ago, explaining his plan for medical care for the aged—a plan embodied in the King-Anderson bill.

The Kennedy-King-Anderson plan is most carefully designed to provide the argument by its proponents that there is no intention to control or interfere with the free practice of medicine. It is aimed specifically at (a) inpatient hospital services, (b) nursing home services, (c) services in the home of the patient, and (d) outpatient hospital diagnostic service.

While there is the usual language barring control of hospitals or doctors, there are elaborate provisions for supervision and for the making of specifications by the Secretary of Health, Education, and Welfare. If these are not controls, it is difficult to find a word that will better suit this procedure.

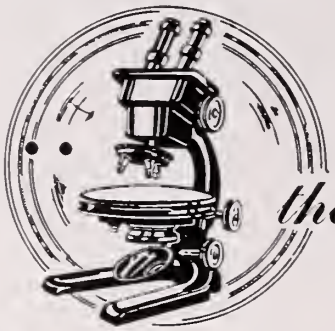
Because the doctor-hospital relationship is close and indivisible, almost every doctor will be controlled by a Government which controls the hospital which he uses for his patients. He needs beds for the patients whom he hospitalizes—patients of all ages. When those beds are preempted by elderly chronic cases, many of whom do not need hospital care, there will be fewer for his emergencies. Hence, there will be overcrowding, and then the Federal Government will have to spend more to provide additional hospitals or additions to existing ones. This vast outlay will rise as the relative proportion of the OASDI (old-age survivors and disability insurance) recipients will certainly rise over the years ahead.

In dealing with the recipients of the Kennedy-King-Anderson plan, countless doctors will have the strong inducement that now confronts them with workmen's compensation cases. That is to "overtreat and overhospitalize" patients. Consider this in connection with the millions of new people under the proposed plan. Both doctors and hospitals will have larger incomes in the first years of this plan. But they will be paying the bitter price of losing their independence.

Doctors will tell you that much of the hospitalization of the elderly is not because of definable illness. It is simply the deterioration which accompanies old age. Also there is the tendency of those who are idle after a life of active work to fall the victim of worry about bodily ailments. The idle mind turns inward, and if there are no specific aches and pains it becomes easy to imagine them.

The Kennedy-King-Anderson plan starts us on a long and probably endless road, a road which we should avoid now and here.



THROUGH . . .  *the Microscope*

An Insurance Man Views the Kennedy Medical Care Plan

The president of the Health Insurance Association of America said February 12 the Administration's proposal for medical care to the aged should not be enacted because it would set up a massive and costly program to meet a relatively small need.

"Our goal should be to provide adequate programs to meet the real needs of the less fortunate members of our society," H. Lewis Ritz said. "Present programs afford this potential. The King-Anderson bill does not because it provides benefits to a large group with no distinction made between the needy, the near-needy, and the rest of our society."

The insurance spokesman said the needs of the indigent and the medically indigent are being met through existing programs, such as the Kerr-Mills program, Old Age Assistance, and efforts on the state and local level. He added:

"All others of our senior citizens can provide for their health care needs through the voluntary system. Substantially more than half of these aged have already done so, and the remainder have a wide variety of plans and programs from which to pick."

Mr. Rietz, who also is executive vice president of the Great Southern Life Insurance Company, Houston, Texas, was the keynote speaker at the Association's annual Group Insurance Forum, held in Chicago. The Association consists of 284 insurance companies responsible for approximately 80 per cent of the health insurance written by American insurance companies.

The insurance spokesman questioned the Administration cost estimates for the King-Anderson bill. He said:

"The Administration estimates that a tax of .5 per cent on $5,200 earnings base would be adequate to finance the King-Anderson benefits. We believe that a tax of 1.66 per cent on $5,200 would be necessary. How great an increase this will mean in social security can be illustrated in another way.

"Today a worker earning $4,800 pays $150 a year in direct social security taxes with his employer paying an equal amount. But with a proposed new $5,200 taxable earnings base, the present social security program with King-Anderson benefits added will result in a worker earning $5,200 paying $283.66 by 1968. This is an 89 per cent increase in the employee's taxes in the space of six years.

"Under our present social security law, employee and employer taxes combined are now scheduled to reach $444 in 1968 for every employee earning $4,800 or more. With the proposed $5,200 taxable earnings base and the addition of King-Anderson benefits such taxes would reach at least $567 by 1968 — an amount well in excess of 10 per cent of the new earnings base."

Medical Examinations for Schoolchildren Urged

The American Medical Association has thrown its full support behind a new nation-wide campaign for periodic medical examinations for young people of school age.

A.M.A.'s continued support of periodic health examinations was expressed in a letter sent to over 1,900 county medical societies by Leonard W. Larson, M.D., A.M.A. president.

Doctor Larson recognized that periodic examinations are already routine in many states and communities. However, there are other places where they are in need of further development.

"I strongly urge constituent medical societies to co-operate with the school authorities and others concerned in working out locally acceptable procedures for such examinations," he said.

Procedures suggested for developing examination programs at the local level are contained in recommendations made by the National Committee on School Health Policies. The recommendations state:

"During their school years children should have a minimum of four periodic medical examinations — at the time of entrance to school, during the intermediate grades, at the beginning of adoles-

cence, and before leaving school. Additional examinations should be made whenever something is suspected to be wrong.

"Medical examinations should be sufficiently painstaking and comprehensive to command medical respect, sufficiently informative to guide school personnel in the proper counseling of the pupil, and sufficiently personalized to provide a desirable educational experience."

A.M.A. Announces Medical Education Loan Fund Plan

The A.M.A. has announced details of its medical education loan program which the association has been developing for the past several months. The loan plan, which will be a function of the A.M.A. Education and Research Foundation, will assist students at any stage of their medical education, including the first year of medical school.

Financing of the program has been negotiated by the A.M.A. with Continental Illinois National Bank and Trust Company, Chicago. Similar financing arrangements will be negotiated with other large banks as the program progresses.

Loans, which will be guaranteed against default by the A.M.A. Education and Research Foundation, will be available to full-time students in good academic standing who are United States citizens, providing they attend a medical school approved by the A.M.A.'s Council on Medical Education and Hospitals or are in residency or internship training in a hospital approved by the Council.

A.M.A.-E.R.F. officials said a lower cost to borrowers will result from centralizing and streamlining through Continental Bank. By agreement, the cost at present during the educational period will be 5½ per cent simple interest.

No payments of principal or interest will be required during the educational or training period and no charge will be made by the bank for carrying the interest that accumulates, an agreement which will result in considerable saving to the borrower. Notes will fall due five months after completion of the training period. Thus, the maximum duration will be seven years and five months — from the first year in medical school through residency. The five-month grace period is intended to provide the physician time to locate after completing residency.

Borrowers will be limited to $1,500 plus interest in any single 12-month period and $10,000 total in a seven-year period. In addition, borrowers may not be indebted for more than $15,000 for educational purposes from all sources.

A new note, known as an "interim note," will be executed each time a student borrows additional funds. Five months after completion of training, the borrower may pay off the final interim note or convert it into a pay-out note which will bear interest at a rate agreed upon at the time the first loan was made. Currently, this interest will not exceed 3½ per cent at an add-on rate.

If the loan to be repaid is less than $7,200, the borrower may choose a level payment of $30 or more a month. For larger loans, a level payment schedule may be chosen, or a 10-year payment schedule selected, with smaller payments initially and progressively larger payments later in the pay-out period.

The borrower will have the privilege of prepaying the loan and thus reducing interest costs. He may also choose to transfer his loan from the Continental Bank to a local bank in the community where he establishes his practice.

Sports Medicine Newsletter Available to Physicians

Medicine in Sports, a newsletter devoted exclusively to reporting the latest information on the care and prevention of athletic injuries, is now being distributed to all physicians interested in the subject as a professional service by the Rystan Company, Mount Vernon, N.Y. Physicians interested in receiving the publication are invited to send their requests to Charles Stanton, editor, *Medicine in Sports,* c/o the Rystan Company, 7 North MacQuesten Parkway, Mount Vernon, N.Y.

The publication, which has been regularly available until now only to physicians in the Eastern states, is intended to fill a gap created by the rapidly growing interest in sports medicine. While many professional journals cover the subject intermittently, *Medicine in Sports* regularly provides rapid summaries of material in the literature, coverage of meetings and symposia on a nationwide basis, and exclusive articles by authorities in the field.

Mass Screening of Newborn Babies With Guthrie Test Planned

The first steps in setting up a new national program which may prevent mental retardation resulting from phenylketonuria and other inborn

continued on next page

DOCTORS' OFFICE-SUITE
FOR RENT

Medical Building

154 Waterman St., corner Cooke St.
Providence

Air Conditioning, Heating and Parking

IMMEDIATE OCCUPANCY

HOWARD REALTY COMPANY
10 Dorrance Street GA 1-5336

errors of metabolism have been announced by Mrs. Katherine B. Oettinger, chief of the Children's Bureau, U.S. Department of Health, Education, and Welfare.

Bureau officials are hopeful that a new test, devised by Doctor Robert Guthrie, associate professor of pediatrics at the University of Buffalo, and so far used to screen more than 3,000 persons in New York for PKU, can be applied on a national basis to newborn infants.

Beginning on July 1, with the co-operation of the health departments and hospitals, a mass screening program of some 400,000 newborn babies will be carried out throughout the nation using the Guthrie test.

The Guthrie test, which uses a few drops of blood from the baby's heel, reportedly detects as early as the first few days of life those babies who have phenylketonuria. Once this fact is established, special diet arrangements can be instituted which will prevent PKU and the subsequent, irreparable mental retardation which is its result.

One of the most hopeful aspects of the new testing procedure is that if the national screening bears out the early findings of the Guthrie technique, infants could receive the test before they leave the hospital.

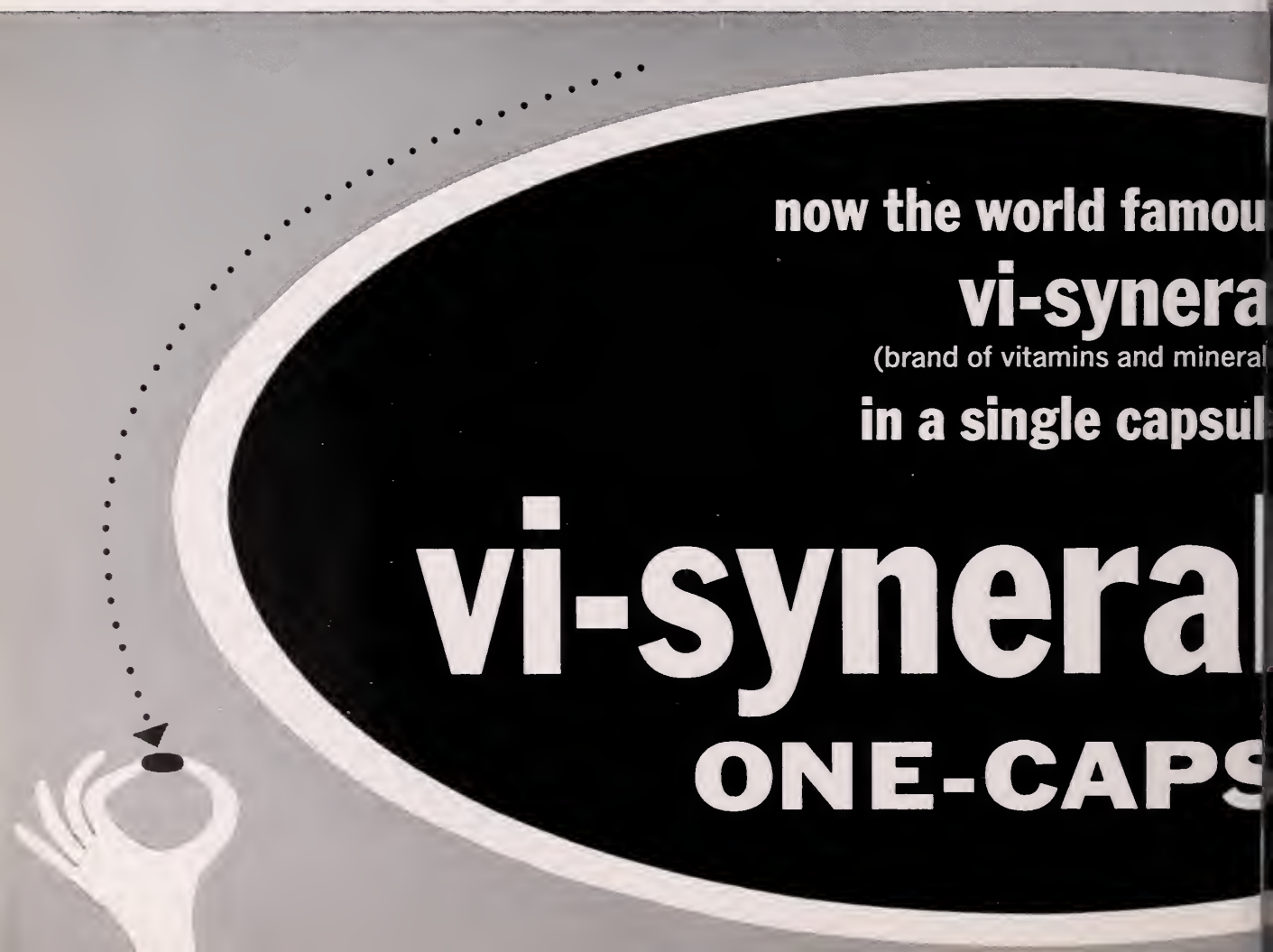
Up to now, the most widely used test has been the simple ferric chloride test of urine, known as the diaper test, which cannot be effectively made until several weeks after birth. It has been used on only 10 per cent of all babies born in the United States.

The hope is that if the testing procedure is widely applicable, it can be extended to devise programs which will prevent mental retardation resulting from other inborn errors of metabolism.

In order to tool up for the year-long screening program, the Children's Bureau is distributing to health officials the information they will need to put the testing procedures into effect. Laboratory technicians who will assess findings are to be trained under Doctor Guthrie's guidance between now and July 1.

Already, more than half of the state health departments have expressed a willingness to co-operate in the new procedure.

While phenylketonuria occurs only once in every 20,000 to 40,000 live births, the condition, if undetected, can lead to such severe mental retardation that lifelong institutionalization is required. Using the diaper test, even on a limited basis, more than 25 infants with PKU were found during 1960 and placed on a diet which will prevent retardation.



Broad Health Plans Getting Even Broader

Six out of every ten workers covered by group health insurance policies issued during 1961 received the broad protection of major medical expense insurance, the Health Insurance Institute reported recently.

Major medical insurance helps pay for virtually all medical services prescribed by a physician, including hospital and surgical care, medicines and drugs, physicians' services, medical appliances, and out-of-hospital diagnostic and X-ray work.

The Institute report was based on its second annual analysis of data supplied by insurance companies which were responsible for 74 per cent of the total group health insurance premiums in the United States in 1960. The 1961 data sampling consisted of some 2,500 new group coverages issued last year protecting 307,355 employees and an estimated 768,400 dependents for a total of more than one million insured individuals.

Will sublet two connecting rooms in modern air-conditioned professional building on Waterman Street in Providence. Separate entrance, parking and janitorial service. All replies confidential.

Telephone DE-1-5024

HEALTH INSURANCE COVERAGE FIGURES

The health insurance coverage figures for all insuring organizations for December 31, 1960, and the estimated figures for December 31, 1961, are given below:

Type of Coverage	*1960*	*1961 (Est.)*
	(in millions)	
Hospital Expense	132.0	136
Sugical Expense	121.0	124
Regular Medical Expense	87.5	91
Major Medical Expense	27.4	35
Loss of Income	42.4	43



TO HELP KEEP RECOMMENDATION OF DIETARY SUPPLEMENTS WHERE IT BELONGS, WITH THE PHYSICIAN

VI-SYNERAL ONE-CAPS offers a high quality product at an especially low price.

• one capsule-a-day dosage • costs your patient less than 3¢ per day

• small, easy to take • ethically promoted, sold through the pharmacy

Each **VI-SYNERAL ONE-CAPS** capsule provides:

VITAMIN A	6,000 U.S.P. Units	DICALCIUM PHOSPHATE	170 mg.
VITAMIN D	600 U.S.P. Units	(Calcium	50 mg.)
ASCORBIC ACID (C)	75 mg.	(Phosphorus	39 mg.)
THIAMINE MONONITRATE (B_1)	3 mg.	FERROUS SULFATE EXSICCATED	50 mg.
RIBOFLAVIN (B_2)	3 mg.	(Iron	15 mg.)
PYRIDOXINE HCl (B_6)	1 mg.	COPPER	1 mg.
NIACINAMIDE	20 mg.	IODINE	0.1 mg.
VITAMIN B_{12}	3 mcg.	MANGANESE	1 mg.
d, CALCIUM PANTOTHENATE	5 mg.	MAGNESIUM	1 mg.
VITAMIN E (d, alpha tocopheryl acetate)	1 Int. Unit	ZINC	1 mg.

Bottles of 28 and 100 capsules.

u. s. vitamin & pharmaceutical corporation

Arlington-Funk Laboratories, division • New York 17, N. Y.

SCANNING THE MEDICAL LITERATURE

OPERATIVE TREATMENT FOR RECURRENT DISLOCATION OF THE TEMPOROMANDIBULAR JOINT. Caroll M. Silver and Stanley D. Simon. J. Bone & Joint Surg. 43-A:211, 1961.

"SUMMARY

"Recurrent dislocation of the temporomandibular joint is an infrequent but disabling condition.

"Surgical treatment is the only therapy of practical value in a well-established condition

"Of the multiple surgical procedures available, we believe that partial section of the insertion of the external pterygoid muscle with meniscectomy is a relatively simple, reliable procedure. This was proposed originally by Boman in 1949.

"A case is presented with five years' follow-up. No recurrence has occurred up to the time of writing, and the clinical result is considered good.

"The surgical technique and aftercare are described."

TREATMENT OF DISINSERTION OF THE BICEPS BRACHII. A. A. Savastano. J. Internat. Coll. Surg. 35:342, 1961.

The history of ruptures of the insertion of the biceps brachii muscle is reviewed in this paper and the anatomy and function of the biceps brachii muscles are also described. The concept that degeneration of a tendon is a prerequisite in most cases to its actual rupture when sudden extension of the fixed, flexed elbow is required, as in lifting a heavy load, appears to be correct. A statistical analysis of thirteen cases observed over fourteen years is presented. It is to be noted that all of the patients in the author's series were males whose lesions occurred mostly during the fifth decade of life. The right arm was involved in nine cases and the left one in four cases. In all cases a sudden force had been exerted on the flexed, fixed elbow. An excellent functional result was obtained in all operative cases. The one case which refused operation had a slight limitation of flexion and supination in the affected arm.

RELAXANT DRUGS IN CEREBRAL PALSY: 1949-1960. Eric Denhoff, M.D., and Raymond H. Holden, Ed.D. New England J. Med. 264:475, March 9, 1961.

A twelve-year program of relaxant drug research in cerebral palsy is reviewed. The requirements for a relaxant drug is one that decreased spasticity, controls dyskinesia and has no influence on normal or weak musculature. It controls hyperkinetic behavior, improves perceptual performance and reduces anxiety. It is acceptable in taste and low in toxicity.

DRUGS EVALUATED BETWEEN 1949 and 1960

Year	Generic Name	Trade Name
1949	Mephenesin	Tolserol
1953	Mephenesin & glycerol alpha-ethyl-gamma-isopropyl ether	Lissephen
1954	Chlorpromazine	Thorazine
1956	Reserpine	Rau-Sed
1956	Zoxazolamine	Flexin
1959	Alpha-ethyl-beta-methylvaleramine	McN 181
1959	Carisoprodal	Soma
1960	Emylcamate	Striatran

In four of the eight drugs studied, the placebo effect was greater than the drug effect. In the neuromotor area, beneficial effects ranged from 9% (Reserpine) to 56% with Mephenesin. In the behavioral effects, favorable changes ranged from 8% (Mephenesin) to 53% (Zoxazolamine). By comparison, improvement on placebo varied from 26% to 50% in the neuromotor area with 17% to 80% in the behavioral area. This demonstrates that placebo had a greater effectiveness in each of the two rated categories when control studies are made.

When drugs admitted in the office practice (uncontrolled studies) were compared against the effects of drugs used in controlled experimental design studies, there was an average improvement of 51.4% in office practice as compared to the average improvement of 38.5% (combined neuromotor and behavior average) in controlled studies. It was felt the placebo effect was high in office practice.

It was recommended that before indiscriminately accepting a new drug beneficial in cerebral palsy, one should rigidly evaluate the neuromotor and behavioral effects against placebo responses. While an occasional drug helps an occasional patient, conclusions concerning relaxant drugs must be made with caution until better objective methods or measurement are available.

ESTABLISHING GOOD COMMUNITY RELATIONS. Gerald Solomons. Collaborative Project Reporter, #21, p. 9, Jan.-Feb. 1961.

To us in Providence, the establishment of good relations with the community is essential to the success of the child development study.

As 60% or so of our babies are followed by private physicians, a letter was sent to each M.D. in Rhode Island explaining the collaborative study, naming the personnel in charge of each phase, and telling how he could be reached.

A report of all examinations is sent to the private doctor even if the results are within normal limits. If the child attends a Child Health Conference (Well-Baby Clinic), only abnormal findings are sent.

The co-operation of adoption and other agencies is excellent and a detailed report is sent to the agency concerned, and in return the agencies encourage the adoptive parents to continue in our study.

Thus our study is able to be helpful to the community while engaging in research for the collaborative project.

MILK ALLERGY IN INFANTILE ATOPIC ECZEMA. Stanley S. Freedman. Am. J. Dis. Child. 102:76, 1961.

There is a prevailing impression among many physicians that allergy to cow's milk is frequently a major cause of infantile eczema. However, available clinical evidence seems to indicate that foods in general and cow's milk in particular have very little, if any, influence upon the course of atopic eczema in infants.

A total of fifty eczematous infants, under two years of age, were studied between 1956 and 1960. They were selected consecutively and subjected to careful clinical scrutiny. Of the total, 34 were private patients and 16 were from the Rhode Island Hospital Pediatric Allergy Clinic. On skin testing, 28% showed positive reactions to milk, 69% to egg white, and 23% to wheat.

The infants in this series were severely allergic patients, and their eczema was more severe than the average. Only those with a final diagnosis of atopic eczema were included in the series. The diagnostic features were:

1. A positive family history of allergy (in parents, siblings, uncles and aunts).
2. A typical age of onset, i.e., from two to four months.
3. Characteristic lesions.
4. Characteristic distribution of lesions.
5. Moderate to severe pruritus.
6. Positive skin tests to food by the scratch technique.

In no instance was cow's milk found to be the sole cause of eczema. In only one instance did the elimination of cow's milk result in a temporary improvement. There was no consistent correlation between the milk changes in the diet and the course of the eczema.

THE PUBLIC HEALTH NURSE AS AN OBJECTIVE SCIENTIFIC OBSERVER. Gerald Solomons, M.D., and Mildred L. Hatton, R.N., B.S. Nursing Outlook 9:486, 1961.

This report on an evaluation of the public health nurse's ability as an objective scientific observer is based on an investigation made in 1960 at the Providence District Nursing Association in Rhode Island.

Fifty infants on the Child Development Study were selected. The results of the four-month pediatric examination and history were tabulated for comparison with the public health nurse's examination and history performed in the home approximately six weeks later. These children were "normal," and particular emphasis on motor development and minor deviations have to be recorded. The nurse had no previous knowledge of the pediatrician's findings.

There was full agreement in thirty-eight cases (76%). All cases classified as normal by the pediatrician were considered normal by the nurse. Broken down into items there was 90% agreement for the fifty cases if the ratings are assessed within one item.

This study has demonstrated that without disturbing a service program, the public health nurse can participate in a national research project and make a significant contribution.

CAPILLARIES AND ARTERIOLES IN NORMAL ENDOMETRIUM. Herbert Fanger, M.D., and Barbara E. Barker, M.S. Obst. & Gynec. 17:543, 1961.

Endothelium of capillaries and arterioles abounds in alkaline phosphatase and these vessels are well demonstrated in thick sections of fresh endometrium using the histochemical technique for this enzyme.

Different vascular patterns are clearly delineated in the proliferative and secretory phases of the menstrual cycle. The vessels of the proliferative endometrium are capillaries of varying caliber and occasional arterioles. In the secretory phase the capillaries are of larger caliber and spiral arterioles are increasingly prominent as the phase progresses.

The vasculature of abnormal endometria and of normal and abnormal uterine cervical mucosa is now being studied.

concluded on next page

STAPEDIAL FRACTURE FOLLOWING HEAD TRAUMA. Mendell Robinson. Laryngoscope 71:181, 1961.

Ossicular injuries are infrequently reported, but the increased use of the operating microscope for conductive hearing losses will undoubtedly result in more findings similar to those described above. Although incudostapedial joint separation has been described and its treatment outlined, no similar papers have been published in regard to stapedial fracture as a direct result of head trauma. This paper should reinforce the principle that not only is a good history necessary when an individual is found to have a conductive type hearing loss, but also that exploratory tympanotomy is an indicated procedure and that reconstruction of the ossicular chain by direct repair or substitution can be accomplished successfully.

STAINLESS STEEL STAPEDIAL PROSTHESIS. A Preliminary Report. Mendell Robinson and Edward I. Seltzer. Laryngoscope 71:385, 1961.

A modification of the Shea polyethylene stapes prosthesis is presented. The new prosthesis is stainless steel. Its design incorporates several features, including a socket for attachment to the incus and a stainless steel wire to serve as a ligament from the prosthesis to the incus. Early results equal those obtained with the polyethylene strut.

OBSERVATIONS ON LEUKEMIC MARROW EXPLANTS IN WELL CULTURES. Patricia Farnes and Frank E. Trobaugh, Jr. J. Lab. & Clin. Med. 57:568, 1961.

By culturing bone marrow flecks with the well technique, acute stem cell leukemias may be further classified into cell type: monocytic, lymphocytic, or myelocytic. The behavior of each cell series on glass as the cells migrate from the fleck reflects itself in typical growth patterns which allow each cell series to be differentiated. The behavior of various marrow elements in culture from leukemic and nonleukemic individuals is discussed.

THE INHIBITORY EFFECT OF COLLAGENASE ON BONE MARROW FIBROBLASTS IN VITRO. Patricia Farnes and Frank E. Trobaugh, Jr. Exper. Cell Res. 24:612, 1961.

"Fibroblast-like cells" develop routinely in bone marrow fleck cultures made according to the well technique. The derivation of these cells has not been established. The development of the FLC may be inhibited for short periods by culturing the cells with collagenase, 0.2 mg/ml. Collagenase has been shown to injure connective tissue elements, but the present study shows that hemic elements are not damaged by this concentration. The study gives further support to the theory that FLC in marrow fleck cultures are derived from connective tissue elements, rather than from hemic cell lines.

MAN'S OCCUPATIONS ON POSTAGE STAMPS. Francesco Ronchese. Indust. Med. & Surg. 30:526, 1961.

A pictorial essay showing how the world honored the worker in various fields of manual and intellectual endeavor by putting farmers, mechanics, weavers, fishermen, postal clerks, musicians, physicians and others on their postage stamps.

A SYRINGE HEATER FOR ANGIOCARDIOGRAPHY. Lester L. Vargas and Thomas Forsythe. Radiology 76:248, 1961.

Advances in the surgical treatment of congenital and acquired heart disease have created a need for precise radiologic demonstration of the cardiac chambers. Sodium acetrizoate (Urokon) had been widely used as the contrast medium in angiocardiography. However, reports calling attention to its nephrotoxic and neurotoxic properties together with a fatality occurring in the authors' experience when this preparation was used, led to their abandoning it in favor of 90 per cent sodium diatrizoate (Hypaque). This preparation had the radiographic qualities comparable to those of Urokon but exhibited less tissue toxicity in the laboratory. However, it had the disadvantage of crystallizing in the syringe at room temperature.

A heating jacket constructed from aluminum was designed by the authors which effectively maintained the temperature of the medium at body temperature throughout the study. The construction of the heater is described in detail in the article.

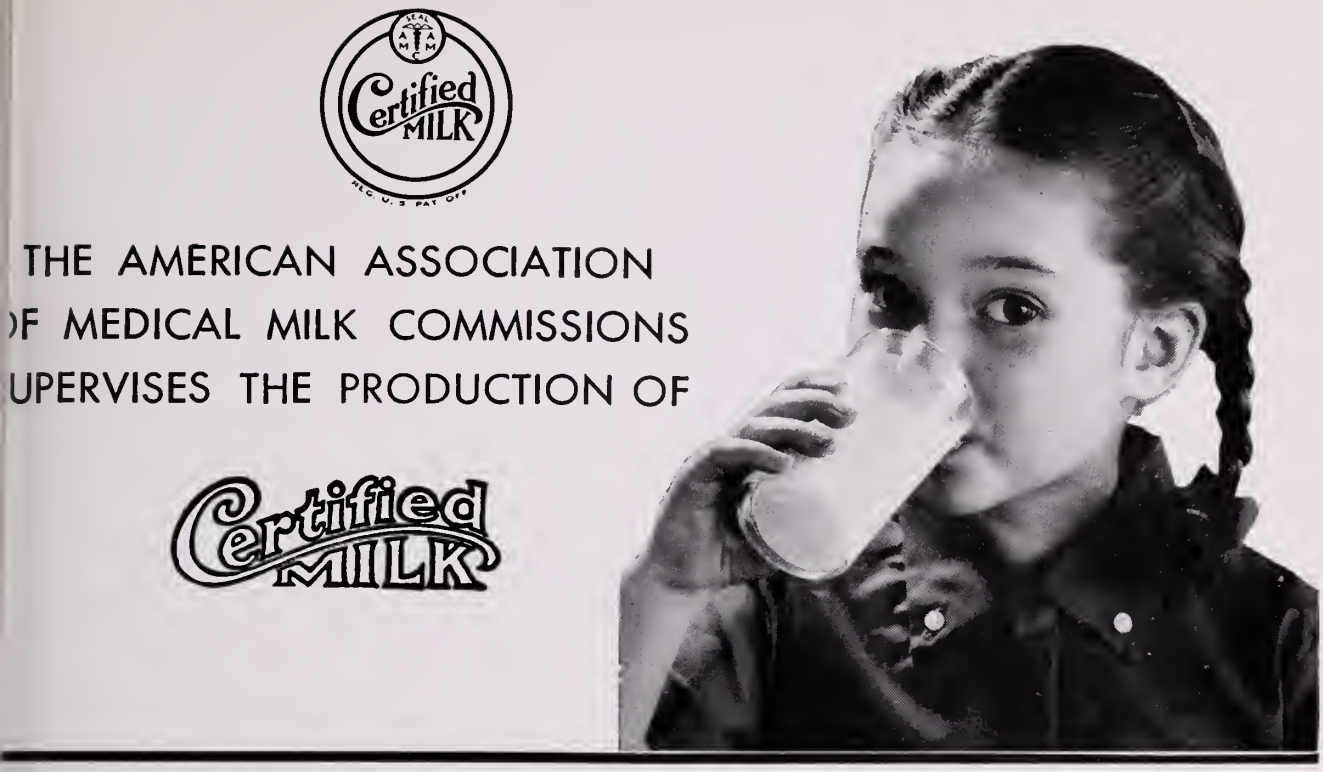
Curran & Burton, Inc.

INDUSTRIAL
AND WHOLESALE

COAL **OIL**

17 CUSTOM HOUSE STREET
PROVIDENCE, R. I.
DExter 1-3315

PATRONIZE JOURNAL ADVERTISERS



THE AMERICAN ASSOCIATION
)F MEDICAL MILK COMMISSIONS
UPERVISES THE PRODUCTION OF

Certified MILK

1. CLEANER. Lowest bacteria-count. Milk checked before each milking. All utensils, bottles, and equipment sterilized before use.

2. BETTER-PROTECTED. Strictest medical supervision of herds and employees. Frequent examinations and laboratory-control AT THE FARM are required.

3. AUTOMATIC MILKING. Cows are milked automatically by electric machine. Milk is bottled without exposure to air or human touch.

4. BOTTLE CLOSURES. Must be of the highest quality to provide complete protection for the milk and bear approval of The American Association of Medical Milk Commissions.

5. MORE NUTRITIOUS. Cows scientifically fed balanced ration. Nutrition control from soil to delivery of milk. Same diet all year.

6. LONGER-LASTING, BETTER-TASTING. Diet control, special handling, and shortest time of delivery from cow to consumer assure fine fresh flavor that lasts for weeks.

7. THE DOCTOR'S MILK. Produced, processed, bottled on farms supervised by Medical Milk Commissions. Each bottle bears the seal of the A.A.M.M.C. and names of the supervising Commission and producing farm.

MILK COMMISSION OF PROVIDENCE MEDICAL ASSOCIATION

HILLSIDE FARMS, INC., 1308 Phenix Ave., Cranston, WI 2-3400
Produced at Hillside Farm, Cranston, R. I.

H. P. HOOD & SONS, 135 Harris Ave., Providence, DE 1-3024
Produced at Hood Certified Farm, Beverly, Mass.

WHITING MILK CO., 40 Tockwotton St., Providence, GA 1-5363
Produced at Hampshire Hills Farm, Wilton, N. H.

Reading time: 1 minute

BRIEFS

FROM THE PHYSICIANS SERVICE PLAN OF THE RHODE ISLAND MEDICAL SOCIETY

April 1962

Physicians Service Claim Form Revised... Must Be Completed in Full

The Physicians Service Claim Form is now being revised, and copies of the new form will be available soon. The revisions will help prevent any possible misunderstandings by the patient, and enable your plan to greatly improve its claims procedure.

However, in order to make the new form effective, it will be necessary that all forms must be completed in full . . . and incomplete forms will have to be returned. Physicians and their secretaries will be provided complete information and instructions concerning the new form soon.

Who Reviews Physicians Service Claims?

When there is a Physicians Service claim which requires individual consideration, or if there is an unusual claims request or questionable claims, the cases are reviewed by the Physicians Service Claims Committee.

18 Physicians Serve: The Claims Committee was recently expanded to 18 Rhode Island physicians, and doctors serving on the committee are rotated periodically, giving different physicians an opportunity to serve.

In addition, there are 11 physicians who serve as consultants to the Claims Committee, representing the various medical specialties.

Meet Weekly: Every Thursday, some members of the Claims Committee meet with J. Lewis Eddy, Physicians Service Claims Director, to pass on some cases and screen out the more questionable claims. Half of the total committee meets once a month to consider these cases.

The combined committee and consultants meet four times a year, and this group also reviews any general problems regarding claims procedures or fee schedules, and makes recommendations for changes to the Physicians Service Board of Directors.

These Physicians Serve: Claims Committee members are: David M. Barry, M.D.; J. Robert Bowen, M.D.; Alphonse R. Cardi, M.D.; William P. Corvese, M.D.; Michael DiMaio, M.D.; Henry B. Fletcher, M.D.; John F. W. Gilman, M.D.; Robert C. Hayes, M.D.; Leland W. Jones, M.D.; Vincent I. MacAndrew, M.D.; Earl J. Mara, M.D.; Francis W. Nevitt, M.D.; Thomas Perry, Jr., M.D.; Richard Rice, M.D.; Charles Round, M.D.; Clarence H. Soderberg, Jr., M.D.; John J. Walsh, Jr., M.D.; Malcolm Winkler, M.D.

Consultants are: Charles J. Ashworth, M.D.; William J. Butler, M.D.; Walter Dufresne, M.D.; Charles L. Farrell, M.D.; Banice Feinberg, M.D.; William C. Howrie, M.D.; Gary P. Paparo, M.D.; Louis A. Sage, M.D.; Richard P. Sexton, M.D.; Louis A. Sheehan, M.D.; Harold W. Williams, M.D.

MAY, 1962

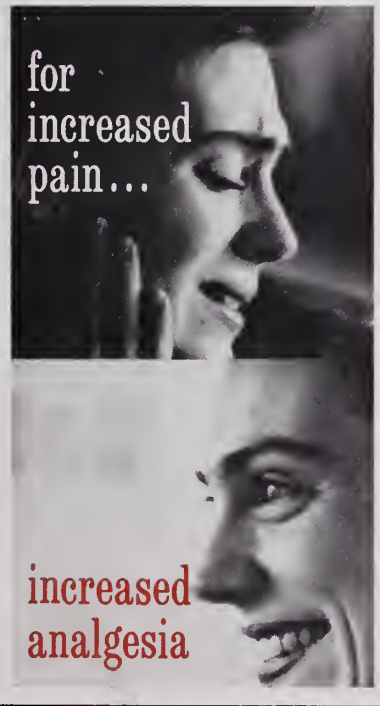
RHODE ISLAND

Medical Journal

LIBRARY
SEP 13 1962
NEW YORK ACADEMY
OF MEDICINE

Volume XLV, No. 5

Table of Contents, page 231



Lilly

DARVON® COMPOUND-65

Darvon Compound-65 provides twice as much Darvon® as does regular Darvon Compound without increase in salicylate content or the size of the Pulvule®. Usual dosage is 1 Pulvule three or four times daily.

Darvon Compound		Darvon Compound-65
32 mg.	Darvon	65 mg.
162 mg.	Acetophenetidin	162 mg.
227 mg.	A.S.A.®	227 mg.
32.4 mg.	Caffeine	32.4 mg.

Darvon® Compound (dextro propoxyphene and acetylsalicylic acid compound, Lilly)
Darvon® (dextro propoxyphene hydrochloride, Lilly)
A.S.A.® (acetylsalicylic acid, Lilly)

This is a reminder advertisement. For adequate information for use, please consult manufacturer's literature. Eli Lilly and Company, Indianapolis 6, Indiana.

220245

"crying solitary in lonely places"



DILANTIN®

(diphenylhydantoin, Parke-Davis)

permits a richer life for the epileptic

"It has been more than twenty years since the introduction of diphenylhydantoin sodium (DILANTIN Sodium) as an anticonvulsant substance. This drug marks a milestone in the rational approach to the management of the epileptic."[1] In grand mal and psychomotor seizures, DILANTIN is a drug of choice for a variety of reasons: • effective control of seizures[1-9] • oversedation is not a common problem[2] • possesses a wide margin of safety[3] • low incidence of side effects[3] • its use is often accompanied by improved memory, intellectual performance, and emotional stability.[10] DILANTIN (diphenylhydantoin, Parke-Davis) is available in several forms, including DILANTIN Sodium Kapseals,® 0.03 Gm. and 0.1 Gm., bottles of 100 and 1,000. Other members of the PARKE-DAVIS FAMILY OF ANTICONVULSANTS for grand mal and psychomotor seizures: PHELANTIN® Kapseals (Dilantin 100 mg., phenobarbital 30 mg., desoxyephedrine hydrochloride 2.5 mg.), bottles of 100. for the petit mal triad: MILONTIN® Kapseals (phensuximide, Parke-Davis) 0.5 Gm., bottles of 100 and 1,000; Suspension, 250 mg. per 4 cc., 16-ounce bottles. CELONTIN® Kapseals (methsuximide, Parke-Davis) 0.3 Gm., bottles of 100. ZARONTIN® Capsules (ethosuximide, Parke-Davis) 0.25 Gm., bottles of 100.

This advertisement is not intended to provide complete information for use. Please refer to the package enclosure, medical brochure, or write for detailed information on indications, dosage, and precautions.

REFERENCES: (1) Roseman, E.: Neurology **11**:912, 1961. (2) Bray, P. F.: *Pediatrics* **23**:151, 1959. (3) Chao, D. H.; Druckman, R., & Kellaway, P.: *Convulsive Disorders of Children, Philadelphia, W. B. Saunders Company, 1958, p. 120.* (4) Crawley, J. W.: *M. Clin. North America* **12**:317, 1958. (5) Livingston, S.: *The Diagnosis and Treatment of Convulsive Disorders in Children, Springfield, Ill., Charles C Thomas, 1954, p. 190.* (6) Ibid.: *Postgrad. Med.* **20**:584, 1956. (7) Merritt, H. H.: *Brit. M. J.* **1**:666, 1958. (8) Carter, C. H.: *Arch. Neurol. & Psychiat.* **79**:136, 1958. (9) Thomas, M. H., in Green, J. R., & Steelman, H. F.: *Epileptic Seizures, Baltimore, The Williams & Wilkins Company, 1956, pp. 37-48.* (10) Goodman, L. S., & Gilman, A.: *The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 187.*

PARKE-DAVIS

92462

PARKE, DAVIS & COMPANY Detroit 32, Michigan



BRIEFS

FROM THE PHYSICIANS SERVICE PLAN OF THE RHODE ISLAND MEDICAL SOCIETY

to assist understanding . . .

HERE IS YOUR NEW PHYSICIANS SERVICE CLAIM FORM

The Physicians Service claim form has been revised to improve your plan's claims procedure and help eliminate any possible misunderstanding by the patient or physician.

The items to be filled in on the new form have been numbered to expedite completion and correspondence. In addition, a more complete explanation of "Service Benefits" is printed on the back of the form to assist in patient understanding of this provision.

The new form has been mailed to all physicians. In order to make them effective in preventing possible misunderstandings, it is necessary that all forms must be completed in full . . . and incomplete forms must be returned beginning June 1, 1962.

SURGICAL - MEDICAL SERVICE REPORT

1. PLEASE TYPE OR PRINT WITH BALL-POINT PEN OR PENCIL AND BEAR DOWN TO INSURE GOOD CARBON COPIES. — FORMS MUST BE COMPLETED IN FULL.
2. THE LAST COPY OF THIS FORM AND THE LAST CARBON SHOULD BE REMOVED BEFORE MAILING — HOLD THE TOP EDGE OF FORM AND PULL THE EXTENDED SHEETS.
3. FORWARD THE ORIGINAL AND DUPLICATE COPIES TO:

RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE
31 CANAL STREET, PROVIDENCE 1, R. I. — TEMPLE 1-7300

TELETYPE CLAIM CARD										
CODE	S-A	Dvery	P O T	STATISTICAL	Disp	Cont	Rel.	Agency	PLAN NUMBER	PATIENT	BY

Space Above for Physicians Service Use

TO BE FILLED OUT BY APPLICANT OR SUBSCRIBER

1. NAME OF PATIENT: Mary F. Smith
   NAME OF APPLICANT: Husband - James
   STREET ADDRESS: 693 Hunt Street
   CITY & STATE: Providence, R.I.
2. LATEST IDENTIFICATION NUMBER(S): 3923F16B
3. PATIENT'S AGE: 45
4. APPLICANT'S PLACE OF EMPLOYMENT: James Mfg. Co.
5. WORKMEN'S COMPENSATION CASE? YES ☐ NO ☒ ? ☐
6. VETERAN'S ADM. CASE? YES ☐ NO ☒
7. Enrolled under PLAN A ☐ PLAN B ☒
8. INDIVIDUAL ☐ FAMILY ☒ Membership.
9. My total annual income (INCLUDING THAT OF MY SPOUSE, IF ANY) is: (Check one) UNDER $2800. ☐ $2801. to $4000. ☐ $4001. to $6000. ☒ OVER $6000. ☐
10. I have read the "Explanation of Service Benefits" on the back of this form and hereby certify that I AM ☒ I AM NOT ☐ entitled to the "Service Benefit" (full payment) provision.
11. SIGNATURE OF APPLICANT OR SUBSCRIBER FOR APPLICANT: Mary F Smith
12. DATE: 10/28/61

TO BE COMPLETED BY THE PHYSICIAN (INCOMPLETE FORMS WILL BE RETURNED)

1. WORKMEN'S COMPENSATION CASE? YES ☐ NO ☒ ? ☐
2. VETERAN'S ADM. CASE? YES ☐ NO ☒
3. DIAGNOSIS: Acute Cholecystolithiasis
4. PROCEDURE PERFORMED: Cholecystectomy
5. CODE NUMBER: 2750

NOTE: Use other side for remarks and supplementary information, especially for cysts, tumors, lacerations, burns, skin grafts, and for services not identical to a listed procedure

6. HOW LONG HAS CONDITION EXISTED? 1 week
7. IS IT ACUTE? YES ☒ NO ☐
8. WERE SERVICES PERFORMED AT HOME? ☐ OFFICE? ☐ IN HOSPITAL? ☒ WHAT HOSPITAL? Providence
9. ACCOMMODATIONS: WARD ☐ SEMI-PRIVATE ☒ PRIVATE ☐ OPERATING OR ACCIDENT ROOM ONLY ☐
10. DATES OF SURGERY: 10/15/61 DATES OF MEDICAL SERVICE:

11. PHYSICIAN'S SERVICE NUMBER	12. PHYSICIAN'S NAME AND ADDRESS	13. PHYSICIAN(S) USUAL FEE	14. PHYSICIAN SERVICE PAYMENT(S)
7	Surgeon or Attending Physician: Walter O. Harris, M.D.	$300	$250
586	Assisting Surgeon: James R. Stevens, M.D	$ 50	$ 45
1113	Anesthetist: Roy Harnett, M.D.	$ 60	$ 50

15. I, a duly licensed physician, personally performed the above services. I did ☒ I did not ☐ accept this patient for "Service Benefits".
16. REPORTING PHYSICIAN (Signature): Walter O Harris DATE: 10/28/61

Claim Number

This section is for the patient to complete . . . you may want to double-check that 12 items are completed.

This section will provide the information needed from the doctor. Again, you should double check to be certain that 16 items are complete before you mail the claim to Physicians Service.

The RHODE ISLAND MEDICAL JOURNAL

Editorial and Business Office: 106 Francis Street, Providence, R. I.

Editor-in-Chief: SEEBERT J. GOLDOWSKY, M.D.

Managing Editor: JOHN E. FARRELL, SC.D.

Senior Editors

ALEX M. BURGESS, SR., M.D. HENRI E. GAUTHIER, M.D.

Advisory Board

(in addition to editors listed above)

JOHN A. DILLON, M.D. JOHN F. W. GILMAN, M.D. ROBERT V. LEWIS, M.D.
PETER L. MATHIEU, M.D. JOSÉ M. RAMOS, M.D. ROBERT W. RIEMER, M.D.
JACK SAVRAN, M.D. LESTER L. VARGAS, M.D.

Owned and Published Monthly by
THE RHODE ISLAND MEDICAL SOCIETY
Second-class postage paid at Providence, Rhode Island
Copyright, 1962, the Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island
Single copies, 25 cents . . . Subscription, $2.00 per year.

Volume XLV, No. 5 May, 1962

TABLE OF CONTENTS

PAGE

THE NATURE OF DISEASE AND THE CARE OF THE PATIENT: THE CHALLENGE OF HUMANISM AND SCIENCE IN MEDICINE, The Fourteenth Annual Dr. Isaac Gerber Oration, *George L. Engel,* M.D. 245

NECK INJURY AND REAR-END COLLISION, *Thomas C. McOsker,* M.D. 252

SPONTANEOUS RUPTURE OF THE NORMAL SPLEEN, A Case Report, *Orland F. Smith,* M.D.; *Mauricio Rodriguez,* M.D., AND *James W. Meade,* M.D. 255

A STUDY OF OBSTETRICS AND GYNECOLOGY 256

DOCTOR ISAAC GERBER, 1885-1952, Masters in Medicine 258

BRIEF SUMMARY OF THE PRESENT STATUS OF SELECTIVE SERVICE AS IT RELATES TO PHYSICIANS 266

EXIT OF DOCTORS TALLIED IN BRITAIN 268

EDITORIALS

Don't You Believe It! 262

Governor Notte and Irresponsibility 263

Affects and Effects 264

Chiropody (Podiatry) 264

DEPARTMENTS

President's Message 233

The Washington Scene 240

Through the Microscope 270

Book Reviews 278

MISCELLANEOUS

Photographs:

Arthur E. Hardy, M.D. 232

Robert R. Baldridge, M.D., and Thomas Perry, Jr., M.D. 234

Other Society Officers 236



ARTHUR E. HARDY, M.D.
of Warwick, Rhode Island
President of the Rhode Island Medical Society
May, 1962 . . . May, 1963

PRESIDENT'S MESSAGE

We are celebrating our 150th anniversary in this year 1962. It is my duty and my good fortune to serve as your president for the next twelve months. I have served organized medicine for many years as a county medical society officer, as a member of the Council, as your secretary, as alternate delegate to the A.M.A., and last year as president-elect. I have watched the gradual increase in the tempo of the cold war to socialize medicine.

All of us have watched Doctor Adelson in action during the past year. He is a "real pro." Under his stimulus we have seen the extension of our political action to the county level. Each local society has met with their legislators. The meetings were friendly and illuminating to ourselves as well as to our guests. We learned that if fifteen people speak to a committee *for* a piece of proposed legislation and only one or two speak *against* it, that numbers can be more persuasive than what we feel is logic.

Although Rhode Island has small representation in Congress, I believe that we should have a speaking acquaintance with our national representatives. I shall try to carry on with Doctor Adelson's plans in these respects.

As we move into the future, I would like to read a quotation from the past. This was written when the medical profession was being lampooned in the press by anti-vivisectionists.

"Saying sharp things is easy enough when one is indifferent to consequences; this is particularly true when the target for sarcasms is an illustrious one. For centuries the doctor has been riddled with pleasantries and sarcasms. If he had not been *good* and *great* he would not have been made a mark for brilliant savageries; if he had not been *good* and *great* he would have been swept away long ago by the flood of sharp but not always sincere criticism. Priests and physicians have from time immemorial come in for a large share of what we might call sportive hostility. The world has laughed over these jocularities, yet at the first appearance of physical or spiritual disquietude the world has sent posthaste for the priest or the doctor." Thus wrote Eugene Field in 1900.

This year, as in the past, the medical profession must be prepared to meet these criteria. — The *good* and the *great*. We must not only be good in an ethical sense, but those that are good must see that the bad among us are brought to justice: not only to preserve the dignity and honor of the profession, but also to preserve the health and welfare of the people.

Some people may think this is a widespread problem. I can assure you it is not. The percentage of physicians who do not observe the law or the dictates of good conscience is infinitesimal compared with the vast majority of doctors who conscientiously provide their patients with the best possible medical care.

In this age of orbiting astronauts we must not only be great in a scientific sense, but also in a medical economic sense. We must widen our vision and adjust our sights to encompass many fields outside the science and art of medicine.

During the next twelve months the answers to questions concerning medicine's continued freedom in this country will further unfold. Will we be caught asleep in a blanket of indifference, or will we be wide awake, keeping abreast of the times and truly advancing the art and science of medicine and the health and welfare of our people? If we can learn from some of our mistakes and take positive action where we have been inactive or neutral; become informed instead of remaining uninformed; if through individual example we restore the image of the physician with the public, we will defeat the present challenge to our freedom.

Arthur E. Hardy, M.D., *President*



ROBERT R. BALDRIDGE, M.D.
of Providence, Rhode Island
Vice President of the Rhode Island
Medical Society
May, 1962 . . . May, 1963

THOMAS PERRY, JR., M.D.
of Providence, Rhode Island
President-elect of the Rhode Island
Medical Society
May, 1962 . . . May, 1963





a relaxed mind in a relaxed body

with

Trancopal®

Brand of chlormezanone

effective TRANQUILIZER ■ potent MUSCLE RELAXANT

When you prescribe Trancopal you can see how this "tranquilaxant" speedily helps the anxious patient. It quiets his psyche — and this quieting helps relax tense muscles. It eases muscle spasm — and this easing helps put the mind at rest.

DeNyse[1] notes that the effect of Trancopal as a quieting agent ". . . may play a part in the skeletal muscle relaxing results obtained." Gruenberg[2] used Trancopal to treat patients with musculoskeletal disorders, and commented: "In addition to relieving spasm and pain, with subsequent improvement in movement and function, Trancopal reduced restlessness and irritability in a number of patients."

Trancopal has an unsurpassed record of safety. Very few side effects occur with Trancopal. You may see them in only about two out of a hundred patients, and they will almost always be mild.

Available: 200 mg. Caplets® (green colored, scored), bottles of 100
100 mg. Caplets (peach colored, scored), bottles of 100

Dosage: Adults, 1 Caplet (200 mg.) three or four times daily;
children (5 to 12 years), from 50 to 100 mg. three or four times daily.

Before prescribing, consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

References: 1. DeNyse, D. L.: M. Times *87*:1512 (Nov.) 1959.
2. Gruenberg, F.: Current Therap. Res. *2*:1 (Jan.) 1960.

Winthrop LABORATORIES New York 18, N.Y.

1649M

Officers, 1962-1963 — THE RHODE ISLAND MEDICAL SOCIETY



MICHAEL DI MAIO, M.D.
of Providence
Secretary



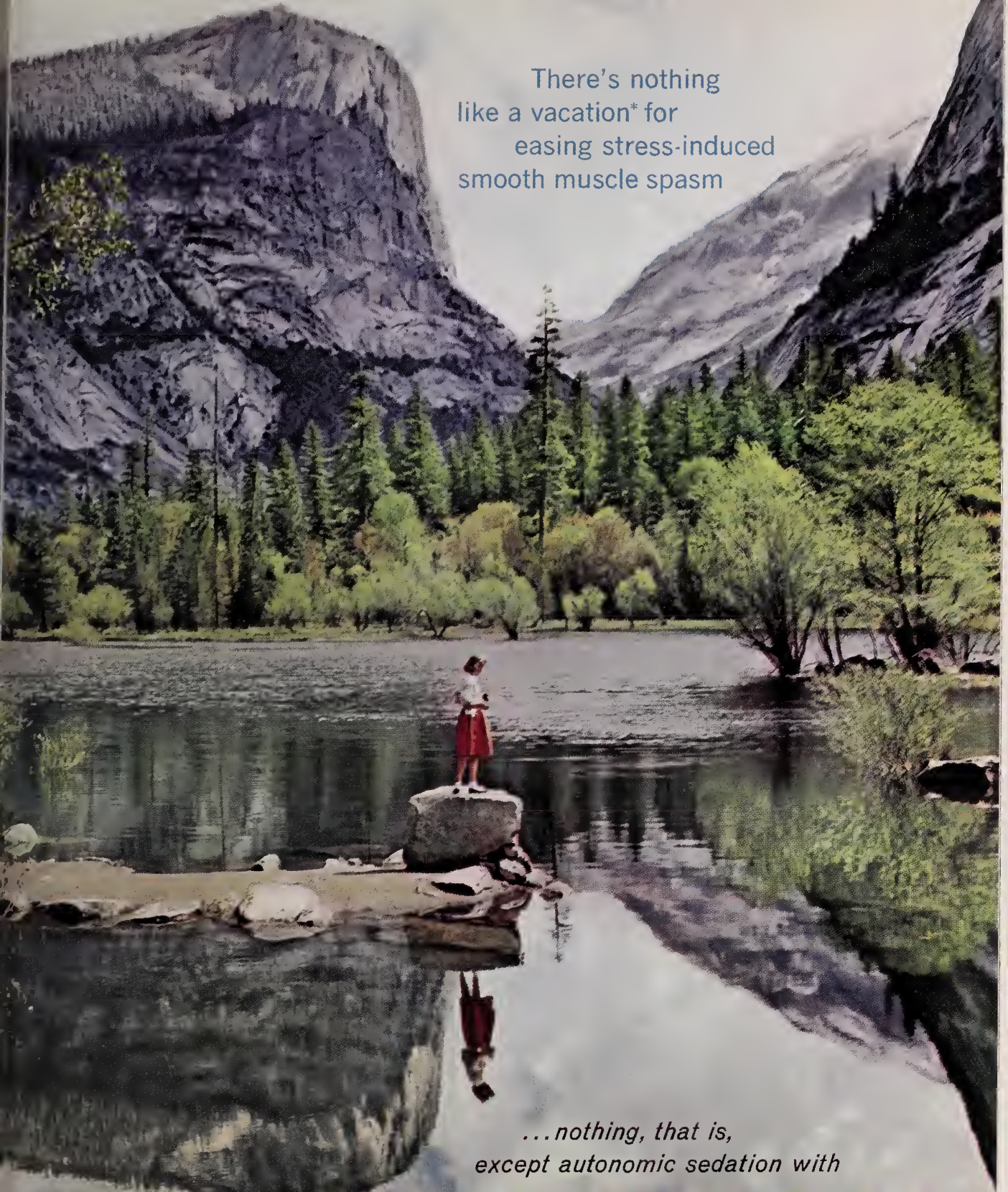
J. MURRAY BEARDSLEY, M.D.
of Providence
Treasurer



CHARLES J. ASHWORTH, M.D.
of Providence
Delegate to the A.M.A.



SEEBERT J. GOLDOWSKY, M.D.
of Providence
Editor-in-Chief
R. I. MEDICAL JOURNAL



There's nothing
like a vacation* for
easing stress-induced
smooth muscle spasm

...nothing, that is,
except autonomic sedation with

Prescribed by more physicians
than any other antispasmodic

DONNATAL®

Natural belladonna alkaloids plus phenobarbital
*This one at Mirror Lake, Yosemite Park

In each DONNATAL Tablet, Capsule or 5 cc. Elixir		In each DONNATAL Extentab
0.1037 mg.	hyoscyamine sulfate	0.3111 mg.
0.0194 mg.	atropine sulfate	0.0582 mg.
0.0065 mg.	hyoscine hydrobromide	0.0195 mg.
16.2 mg. (¼ gr.)	phenobarbital	(¾ gr.) 48.6 mg.

DONNATAL tablets • capsules • elixir
— for an easily adjusted t.i.d. or q.i.d. dosage regimen.

DONNATAL EXTENTABS®
— for day-long or night-long benefits on a single dose.

A. H. ROBINS CO., INC. • Richmond, Virginia


effective skeletal
muscle relaxatio

s each patient may require



control the two-headed dragon of *pain & spasm*

"HIGH THERAPEUTIC EFFECT"

A growing library of clinical reports on the use of ROBAXIN in painful skeletal muscle spasm continues to reaffirm its effectiveness, dependability, rapidity of action, and lack of significant side effects.

Some recent comments:

"...high therapeutic effect..."[5]

"...superior to other relaxants..."[9]

"...remarkably effective..."[2]

"...a high potential for prompt relief..."[8]

"...unusual freedom from toxicity..."[1]

for dramatic promptness: ROBAXIN INJECTABLE usually provides relaxation of painful spasm *in minutes.* Clinicians have reported that it is "effective in producing immediate relaxation,"[7] and brings about "dramatic relief of pain and spasm" within 15 to 20 minutes.[3]

In each 10-cc ampul Methocarbamol (Robins) 1.0 Gm.

for prolonged use with safety: ROBAXIN TABLETS safely maintain relief of spasm *without drowsiness.* "The effect does not wax and wane,"[4] and continued administration shows "no deleterious effect on normal muscle tone."[6]

In each white, scored tablet Methocarbamol (Robins) 0.5 Gm.

ROBAXIN®

Robaxin is methocarbamol (Robins) U. S. Pat. No. 2770649

for concurrent analgesia: ROBAXISAL TABLETS, combining ROBAXIN with aspirin, are useful in spasm-triggering states that are painful in themselves, or when pain is prominently associated with muscle spasm.

In each pink-and-white laminated tablet Methocarbamol (Robins) 400 mg.
Acetylsalicylic acid (5 gr.) 325 mg.

for concurrent analgesia plus sedation: ROBAXISAL-PH TABLETS, combining ROBAXIN with the sedative-reinforced analgesic PHENAPHEN®, are particularly helpful in giving comprehensive relief to patients in whom muscle spasm is accompanied by spasm-potentiating pain and apprehension.

In each green-and-white laminated tablet			
Methocarbamol (Robins)	400 mg.	Acetylsalicylic acid (1¼ gr.)	81 mg.
Phenacetin	97 mg.	Hyoscyamine sulfate	0.016 mg.
		Phenobarbital (⅛ gr.)	8.1 mg.

ROBAXISAL®

References: 1. Carpenter, E. B.: South. M. J. 51:627, 1958. 2. Hudgins, A. P.: Clin. Med. 8:243, 1961. 3. Lamphier, T. A.: J. Abdomin. Surg. 3:55, 1961. 4. Levine, I. M.: Med. Clin. N. America 45:1017, 1961. 5. Meyers, G. B., and Urbach, J. R.: Penna. M. J. 64:876, 1961. 6. Perchuk, E., Weinreb, M., and Aksu, A.: Angiology 12:102, 1961. 7. Poppen, J. L., and Flanagan, M. E.: J.A.M.A. 171:298, 1959. 8. Schaubel, H. J.: Orthopedics 1:274, 1959. 9. Steigmann, F.: Am. J. Nursing 61:49, 1961.

A. H. ROBINS COMPANY, INC. • Richmond, Virginia

AN AMES CLINIQUICK®
CLINICAL BRIEFS FOR MODERN PRACTICE

WHY TEST URINE ROUTINELY FOR PROTEIN ?

In a recent series of 278 diabetic patients, 34.2 per cent (95) had proteinuria. Of this group, almost 3 out of 5 had previously unrecognized renal disease, usually asymptomatic and untreated.[1] Proteinuria may give valuable warning not only of infectious and other renal disorders, but also of degenerative diabetic nephropathy.[2]

With URISTIX Reagent Strips, testing for proteinuria *and* glucosuria may be conveniently done at the same time. URISTIX is "... reliable for routine clinical use."[1] It will not give false-positive protein reactions with oral hypoglycemic agent metabolites. URISTIX is simple for patients to use at home and is timesaving for technicians.[1]

References: (1) Moss, J. M.; Schreiner, G. E., and Sweeney, V.: M. Times *89*:12 (Jan.) 1961. (2) El Mahallawy, M., and Sabour, M. S.: J.A.M.A. *173*:1783 (Aug. 20) 1960.

for broader day-to-day protection of the diabetic patient

DIP AND READ

uristix®

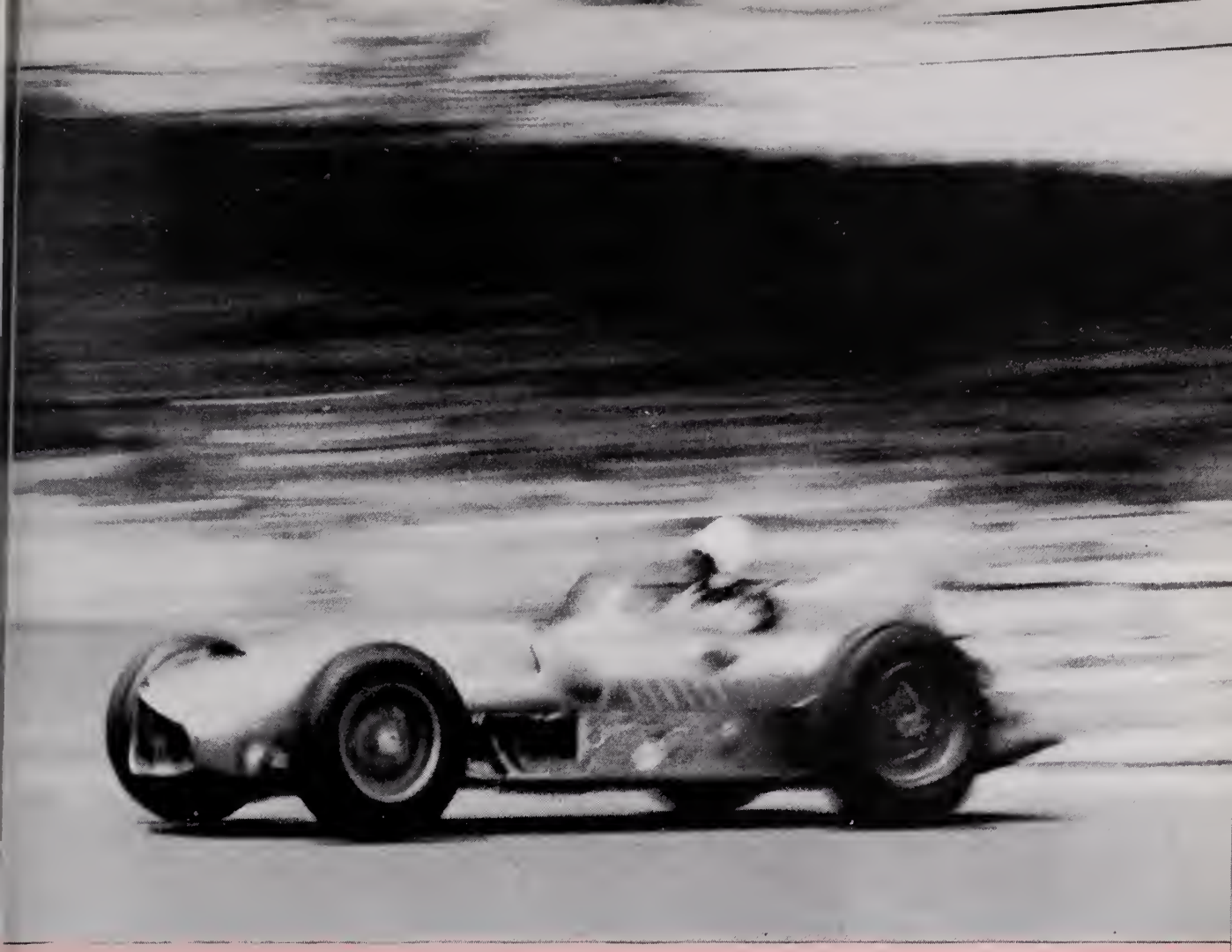
urine protein · glucose

AMES COMPANY, INC
Elkhart • Indiana
Toronto • Canada

1 dip . . . 10 seconds . . . 2 readings

available: URISTIX Reagent Strips, bottles of 125

20062



PERCODAN BRINGS *SPEED*...DURATION... AND DEPTH TO ORAL ANALGESIA

in the wide middle region of pain

PERCODAN®

(Salts of Dihydrohydroxycodeinone and Homatropine, plus APC) TABLETS

fills the gap between mild oral and potent parenteral analgesics

■ acts in 5-15 minutes ■ relief usually lasts 6 hours or longer ■ constipation rare ■ sleep uninterrupted by pain

Literature on request

Endo®

ENDO LABORATORIES
Richmond Hill 18, New York

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Federal law allows oral prescription. *Also Available:* Percodan®-Demi: the complete Percodan formula, but with only half the amount of salts of dihydrohydroxycodeinone and homatropine.

Each scored, yellow Percodan* Tablet contains 4.50 mg. dihydrohydroxycodeinone HCl, 0.38 mg. dihydrohydroxycodeinone terephthalate (warning: may be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. acetophenetidin, and 32 mg. caffeine.

*U.S. Pats. 2,628,185 and 2,907,768

THE WASHINGTON SCENE

A Summary Report Issued by the Washington Office of the American Medical Association

SUPPORTERS of the King-Anderson bill stepped up their campaign as the House Ways and Means Committee neared a showdown vote on the legislation which would provide limited health care for the aged under social security.

The Kennedy Administration took over the leadership in the drive with the President accepting an invitation to address a rally in Madison Square Garden, New York City, on May 20 sponsored by the National Council of Senior Citizens for Health Care Through Social Security.

The Administration also was organizing citizens' committees in individual states to whip up grass roots pressure for the bill. The President was asking prominent persons, such as former Democratic Governor and U.S. Senator Edwin C. Johnson in Colorado, to head such committees.

After personally pledging their support to the legislation in a White House call on the President, 27 physicians formed The Physicians Committee for Health Care for the Aged Through Social Security headed by Doctor Caldwell B. Esselstyn of New York City, president of the Group Health Association of America. Most of the 27 are educators, hospital administrators or in other administrative posts. A majority are members of the A.M.A.

Pointing out that the White House was able to muster only an insignificant number of doctors for the King-Anderson bill, an A.M.A. spokesman said at least 90 per cent of the nation's 261,000 physicians are opposed to the legislation.

The intensified Administration drive made it imperative that physicians and other opponents of the Social Security approach go all-out at this time in their efforts against the King-Anderson bill.

A vote was expected in the Ways and Means Committee in May or June at the latest.

Senator Robert S. Kerr (D., Okla.), reaffirmed his opposition to the King-Anderson bill but said he expected it would come up on the Senate floor for a vote. He said he and Representative Wilbur D. Mills (D., Ark.), chairman of the Ways and Means Committee, were conferring on legislation that would expand the Kerr-Mills program — which has the wholehearted support of the A.M.A. — to cover more aged persons.

Under the leadership of Representative William E. Miller (R., N.Y.), who is also chairman of the Republican National Committee, some Republican Congressmen got behind the so-called Bow bill which would permit aged persons to reduce their federal income taxes by up to $125 a year to cover health insurance premiums. The government also would issue to persons 65 years and older who pay no income taxes, or less than $125 a certificate with which to purchase health insurance.

* * *

The Public Health Service licensed Type III oral poliomyelitis vaccine but left the decision to local health officials and physicians as to whether the oral or the Salk killed vaccine, or both, would be used this year.

Types I and II oral polio vaccine had been licensed last year and Type III was the last of the series needed for protection against all three types of polio.

Production and availability of the oral vaccine will be a major factor in the extent of its use this year.

The PHS conclusion on local immunization programs was recommended by a special advisory committee to the Surgeon General and was in line with a policy adopted by the A.M.A. House of Delegates at Denver, Colorado, last November.

The PHS gave five guidelines for the local programs:

1. Organizers of community drives must be assured that adequate supplies are available before such programs are undertaken.

2. All persons in those groups selected by the community should receive vaccine regardless of past polio immunization history.

3. In general, vaccination programs using either vaccine must have careful planning and achieve a maximum of support from official and voluntary health and medical groups.

4. The plans should assure the ready availability of the vaccine in all areas of the community and for all persons within the selected target groups. Special emphasis must be directed to those areas and population groups having the lowest levels of immunization. Community-wide programs should achieve the immunization of the maximum number of persons, but no less than 80 per cent of the preschool children in all socioeconomic groups.

concluded on page 242



Today's little "limey" needs a half barrel of orange juice

...or, to be exact, a total of 2,106 ounces in his first two years. And how much he'll need during his first twenty years would have to be measured by the truckload, because the need for the nutrients contained in Florida orange juice continues throughout life.

How our little "limey" or any of your other patients obtain the vitamins and nutrients found in citrus fruits is important to them and to you. There are so many wrong ways, so many substitutes and imitations for the real thing.

For a way that combines real nutrition with real pleasure, there's nothing better than the oranges and grapefruit ripened under Florida's own sunshine. Somehow, nothing can surpass the result of the combination of sun, air, temperature, and soil found in Florida.

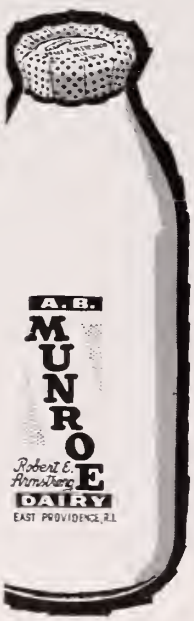
It's good nutrition to encourage people to drink orange juice. It's even more judicious to encourage them to drink the juices and eat the fruits watched over by the Florida Citrus Commission. These men set the world's highest standards of quality in fresh, frozen, canned, or cartoned citrus fruits and juices.

When you suggest to your patients that they have a big glass of orange juice for breakfast, or for a snack, or when they want to raid the refrigerator, the deliciousness of Florida orange juice will give you assurance that they'll *want* to carry out your recommendation. You'll be helping them to the finest drink there is—by the glassful or the barrel.

© Florida Citrus Commission, Lakeland, Florida

AS CLEAN
AS MODERN
DAIRY SCIENCE
CAN MAKE IT...





The A. B. Munroe Dairy Laboratory, where milk is subjected to constant testing, using the most modern methods of milk analysis.

Through every step in processing, from the immaculate receiving room to pasteurizing and homogenizing, on through bottling and refrigeration, the A. B. Munroe Dairy observes the strictest standards of dairy hygiene. The spotless surroundings and rigid quality control are so designed that all A. B. Munroe Dairy products that reach your table are as fresh, wholesome and pure as modern science can make them.



A. B. MUNROE DAIRY, INC.
151 Brow Street, East Providence, Rhode Island

Call GE 8-4450
for Home Delivery

THE WASHINGTON SCENE

concluded from page 240

5. A continuing program of immunization of infants should be incorporated as an essential feature of all organized community-wide programs.

The PHS also recommended that the three types of oral vaccines be administered sequentially, each in monovalent form at intervals of about six weeks.

"Optimally," the PHS said, "large scale immunization campaigns with oral poliovirus vaccines should be conducted during the winter or spring months."

Doctor Luther L. Terry, surgeon general of the PHS, termed the licensing of the Type III oral vaccine as "another major step toward the final conquest of paralytic poliomyelitis."

"Now, two effective weapons, the formaldehyde-inactivated vaccine and the oral vaccine, are available for general use," Doctor Terry said. "Their proper application should accelerate the decline in poliomyelitis and could lead to the early elimination of the disease."

The PHS called for emphasis this year on vaccination of the unimmunized and inadequately protected with one or the other of "these effective vaccines (or a combination so long as there is at least a complete series of either) and also to the initiation of as many well-organized community-wide programs as the supply of vaccines will permit."

The PHS set four priorities in use of the polio vaccines:

1. Vaccination programs in areas threatened with epidemics. The PHS Communicable Disease Center at Atlanta, Ga., will keep on hand supplies of oral vaccine to meet this need.

2. Routine immunization of infants, starting when six weeks old and completed in twelve months.

3. Immunization of preschool children.

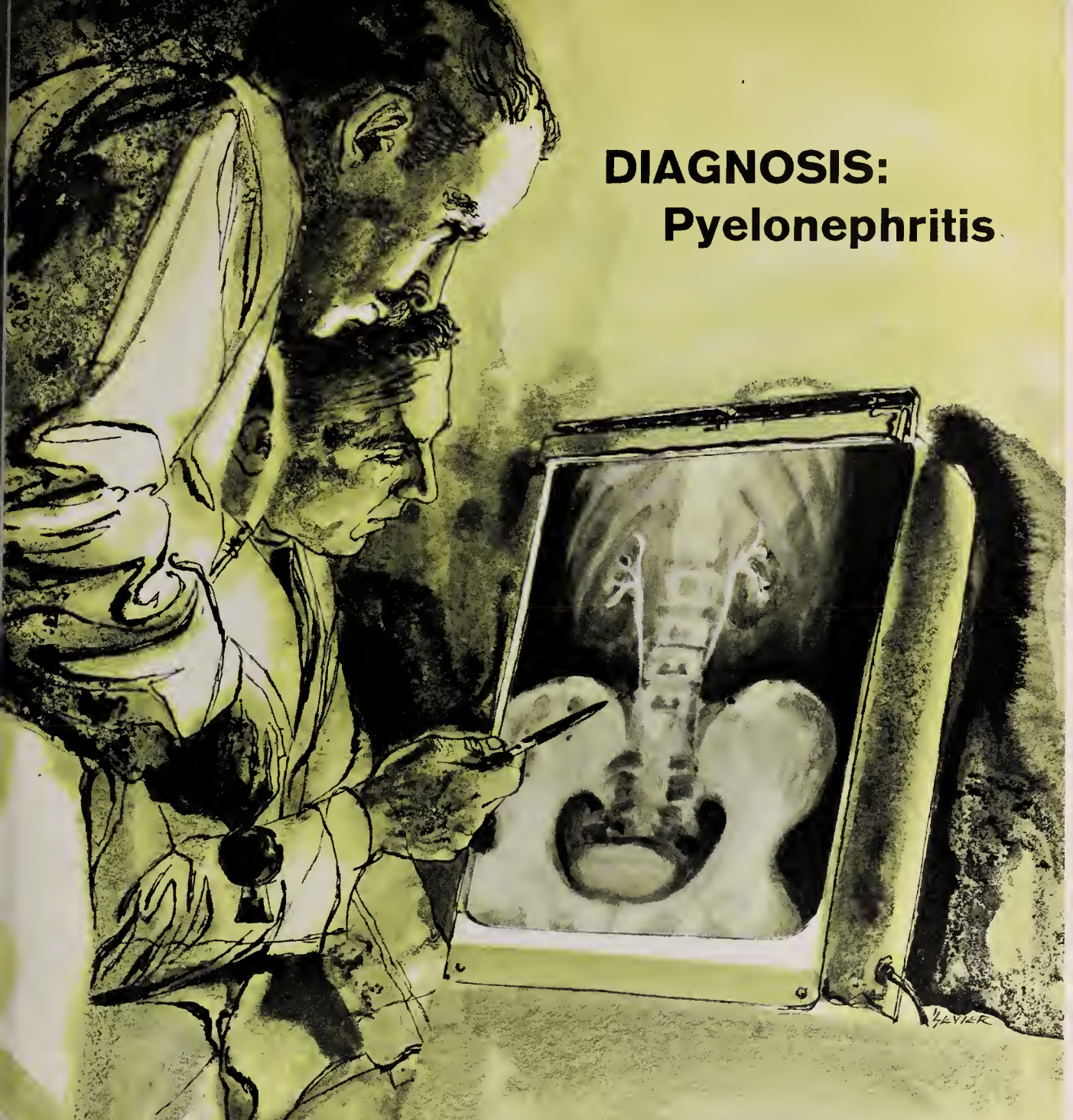
4. Immunization of young adults and parents of young children.

DOCTOR'S OFFICE

Broad Street 708, near St. Joseph's Hospital, 4 or 6 rooms.

Ideal location, will remodel to suit

STuart 1-2288



THERAPEUTIC NEED: Rapid suppression of causative organisms and attention to fluid requirements.

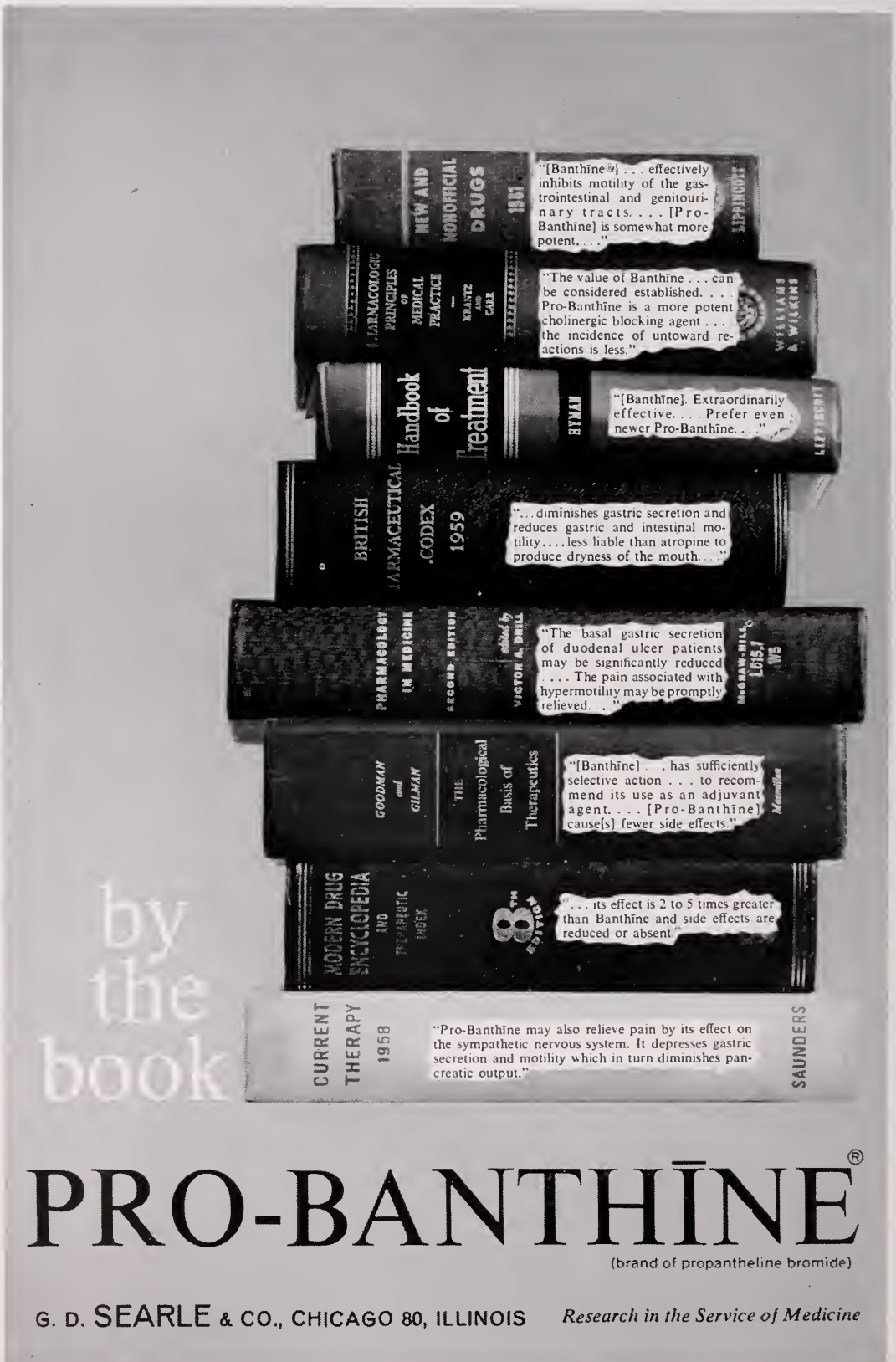
ANTIBIOTIC: DECLOMYCIN®

Demethylchlortetracycline Lederle

because it is highly effective against the common pathogens in G. U. infections.

quest complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

EDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York Lederle



PRO-BANTHĪNE®

(brand of propantheline bromide)

G. D. SEARLE & CO., CHICAGO 80, ILLINOIS *Research in the Service of Medicine*

The RHODE ISLAND MEDICAL JOURNAL

VOL. XLV MAY, 1962 NO. 5

The Fourteenth Annual Dr. Isaac Gerber Oration

THE NATURE OF DISEASE AND THE CARE OF THE PATIENT: THE CHALLENGE OF HUMANISM AND SCIENCE IN MEDICINE*

GEORGE L. ENGEL, M.D.

The Author. *George L. Engel, M.D., Professor of Psychiatry, and Associate Professor of Medicine, the University of Rochester Medical Center, Rochester, New York.*

IN RECENT YEARS it has become fashionable to stress the importance of the doctor-patient relationship and the necessity to consider the "patient as a whole." Many are concerned that the humane aspects of medicine are being submerged by the emphasis on the scientific and technical. Efforts are being made to modify medical curricula so as to enable the student to relate to the patient rather than to the disease. In brief, physicians and medical teachers are again concerning themselves with the so-called art of medicine. These developments raise the question as to whether this interest in the doctor-patient relationship is primarily a reflection of our humanism as physicians or whether it has some specific scientific relevance for the course of disease, the maintenance of health, and the care of patients. Are we concerned that we have "good" relationships with our patients, that our patients like and have confidence in us, only because this is the way decent human beings should behave with each other? Is it a matter of public relations and a good press for the physicians, as some of the spokesmen of organized medicine would have us believe? Or is it possible that between physician and patient there transpire certain psychobiological processes (basic to human relations in general) which have significance for the capacity of the individual to maintain health or to develop disease? In brief, in respect to health and disease, is the bond between patient and physician a matter of science or of humanism? I propose that it is primarily a matter for science and further that that which is humanistic in medicine also has a scientific basis.

*Presented at Miriam Hospital, Providence, Rhode Island, on October 18, 1961.

First presented at the Dedication Symposium of the Neuropsychiatric Institute, University of California Medical Center, in March, 1961, and now in a chapter of PSYCHIATRY IN MEDICINE, edited by Norman Q. Brill, M.D., published by the University of California Press, 1962.

That the physician can exercise a healing effect without the exhibition of any specific treatment has been known and exploited by physicians throughout the ages. Indeed, so striking are the effects of physician on patient that one might wonder how much this contributed to the survival of medicine as a profession, since what we know as scientific medicine is hardly 100 years old and even now the number of specific curative remedies are few and far between. From time immemorial human beings have sought, found, and used healers and it is this need of the suffering and ill which has kept medicine as a profession alive through its millenia of dark ages and into its present scientific infancy.

Is our understanding of health and disease sufficiently encompassing to take into account such factors? Disease is a condition of life; it is not something set apart. As Dubos has said, "The very process of living is a continual interplay between the individual and his environment, often taking the form of a struggle resulting in injury or disease."[1] Health and disease accordingly are relative concepts reflecting in essence the degree of success or failure of growth, development, and adjustment in a physical, biological, and social environment.[2,3,4] Departures from health or disturbances in adjustment are multi-determined. Simple cause and effect views of disease are no longer tenable.[5] Our modern concept of disease must include all the parameters that bear on life itself, be they observable in physical, chemical, biological, genetic, morphologic, psychologic, interpersonal, or social terms. Whether considering how health is maintained or how disease evolves, we no longer will be concerned with the single "cause" but with the necessary *and* sufficient conditions underlying each. And the conditions of health and of disease are the conditions of life.

Once we have so broadened our horizons we discover a banality. Man lives by more than bread alone. Health and healthy development require certain kinds of experience and human contact over and above the other well-known essentials, oxygen, water, nutriment, and so on. Indeed, some have

continued on next page

even used such terms as "nutriment" or "aliment" to identify the essential input to mind, apparently necessary not only for its growth and development, but for the well-being of the individual himself.[6,7] This dependence on such supplies from the environment is so obvious that it tends to remain unnoted until some situation arises in which they are unavailable. Then, as the poets and philosophers have long informed us, profound changes in well-being may take place in the one so deprived, including even a decline to death. So far such matters have been dealt with largely in spiritual, religious, or artistic terms; and scientists have given them scant heed. True, the great physicians, as sensitive observers of the human scene, were impressed with the significance of such antecedents as despair and grief as possible factors in the genesis of many illnesses, including neoplasm, and stressed the role of faith and hope in recovery.[8,9] But with the explosive developments in scientific medicine of this century interest in and awareness of such factors have been largely eclipsed by the contributions of the physical sciences to biology and medicine. While tremendous new insights into psychology and the mind, ushered in and stimulated by the discoveries of Freud, were evolving at the same time, for the most part the developments in biology and psychology remained unrelated. Now at long last it is becoming clear that a scientific basis exists for what has so far been known mainly through the insights of poets and of the intuitive, sensitive men of all ages. It is the demonstration that certain aspects, processes, and characteristics of the external environment are assimilated by the developing organism, internalized, so to speak, and come to constitute conditions for living, if not for life itself. The terms *objects* and *object relationships* are convenient ones to designate such phenomena. More specifically, objects (for humans) include not only other human beings but also valued possessions, home, job, country, ideals, goals, and so forth, that is, both real persons or things in the environment as well as abstractions. Object relationship refers to the nature and variety of interactions between a person and his environment which account for someone or some thing becoming an object. Obviously, these processes are mediated by the central nervous system and no doubt future study will reveal the nature of the underlying neurophysical and neurochemical events in the brain.[10] But at the moment our greatest and most fruitful insights into these processes are through psychological studies and the observation of mental processes and behavior.

How can we demonstrate the importance of objects and object relationship? The traditional technique in biology for exploring whether or not some element is necessary for life or vital functions is to see what happens when it is not available or is in short supply. In respect to the essentialness of objects, this has long existed as an experiment of nature. I refer here to the phenomenon of grief, the familiar reaction to the loss of an object, be it a loved person, a valued possession, one's job, one's home or one's country elsewhere, to emphasize the role of object relationships and the significance of loss of objects as conditions of life and living. I posed the question as to whether grief could be considered as a disease state in the same sense as pneumonia, a vitamin deficiency, a burn, or a neurosis.[11] Uncomplicated grief is a discrete syndrome which runs a consistent course modified mainly by the abruptness of the loss, the nature of the preparation for the event, and the significance for the survivor of the lost object. When acute, it generally includes an initial phase of shock and disbelief in which the sufferer attempts to deny the loss and to insulate himself against the shock of reality. This is followed by a stage of developing awareness of the loss, marked by the painful affects of sadness, guilt, shame, helplessness or hopelessness, by crying, by a sense of loss and emptiness, by anorexia, sleep disturbances, sometimes somatic symptoms of pain or other discomfort, loss of interest in one's usual activities, impairment of work performance, and so forth. Finally, there is a prolonged phase of restitution and recovery during which the work of mourning is carried out, the trauma of the loss is overcome, and a state of health and well-being re-established. Thus, like other conditions that we customarily think of as disease, it involves suffering, an impairment of function and capacity to work, an identifiable and consistent etiologic factor, namely the real, threatened, or even phantasied loss of an object, and it has a relatively predictable symptomatology and course. The grieving person is often manifestly distressed and disabled to a degree which is quite evident to the observer.

Many find objectionable the inclusion of grief in the general category of disease. These objections are discussed at length elsewhere.[11] Suffice it to say that grief is a natural response to a loss in the same sense that a burn is a natural response to thermal radiation or that typhoid fever is the natural response to the typhoid bacillus in a susceptible individual. That it is ubiquitous and in most instances self-limited, not requiring the ministrations of a physician for recovery, can be said as well of a host of other disease states. While its manifestations are observable in psychologic and behavioral terms, the absence so far of physiologic and biochemical changes during grief do not permit the claim that none occur. Actually, the matter has not yet been studied. That grief is not fatal is not only irrelevant but may not even be true, at least if we are to believe the innumerable accounts that appear

in literature as well as in the press of individuals falling ill and dying during states of grief. Actually, the older medical literature is replete with alleged examples of this[8,9] and we are beginning to find confirmation in current studies, as recently summarized by Schmale.[12] Other arguments have been raised and considered. But even if the skeptic continues to find it difficult to link the terms grief and disease, no one can refute the reality of the phenomenon or the support that it brings to the concept that objects and sustained on-going object relationships, as defined above, constitute necessary conditions for the maintenance of the optimum condition of life that we refer to as health.

Now I selected grief because it is the most obvious, patent, and glaring illustration of the consequences of object loss and one which is familiar to all. It calls to our attention the necessity to learn more about how object relations develop from early life onward, what roles such processes play in the development of the mental apparatus and of the central nervous system. It raises questions as to how such processes may be concerned with the psychological and social development of the individual as well as with the regulation of the internal milieu. It calls for more precise identification of psychological, behavioral, as well as physical expressions of changes in object relating, for it is as important to know what occurs when objects are gained or object relationships established as it is to know what happens when they are lost or disrupted. There is a large psychoanalytic literature on object relationship but in respect to the genesis of disease, the work of my associates, William Greene, Franz Reichsman, and Arthur Schmale, have provided important new insights. Schmale has pointed out that affects provide the most sensitive psychological indicators of the condition of object relationships and object relating.[12] Further, it is also clear that self-esteem, the intactness of the psychological perception of self, is contributed to in an important way by the nature and status of the past as well as current object relationships and objects. Schmale's work has particularly indicated the affects of *helplessness* and *hopelessness* as those characteristic of "giving up" consequent to object loss. Both these affects have their origins early in life, early in the development of the mental apparatus, and both bespeak the need for objects to maintain psychological integrity and intactness. Both are experienced subjectively as feelings of despair and discouragement, being let down, left out, overwhelmed, too much, and so forth. With *helplessness* this state is perceived as coming from a change in relationship leading to a desire to be taken care of and protected by an object. With *hopelessness*, however, the feeling is that no help is possible, that even if an object or support from the outside becomes available, it will not help, it is too late. Whether or not one "gives up" consequent to object loss, be it real, threatened, or phantasied, is determined by many factors in the past development as well as on the current scene and cannot be predicted by the nature of the object lost or threatened. Therefore, grief includes these affects only to the degree that the loss leads to "giving up," and the distinction between normal grief and unresolved grief will in part reflect the capacity of the individual to deal with the loss and to acquire and use new objects. The observations of our group as well as of many others suggest that when object loss is not successfully dealt with, more complex illnesses, including organic disorders, are likely to develop.[12] And just as helplessness and hopelessness are the affect qualities indicating giving up consequent to object loss, joy, confidence, hope, self-esteem are the affects indicating successful, effective object relationships and the intactness of the self.

Now at this point it may be helpful to provide some objective documentation of the nature of these states and this can be done most conveniently with the aid of a motion picture record of some varieties of response to object loss among young children. Small children are better for illustrative purposes since more of the phenomenology is manifest in behavioral terms and can easily be observed and recorded.

(A 20-minute motion picture was shown.) The first part demonstrated an 18-month-old boy who was entering the hospital for major surgery. This child was born with a congenital atresia of the esophagus and a gastrostomy was performed during the first days of life, through which he has been fed ever since. The child had been under observation since birth and the motion picture record is available at intervals thereafter. He has been very attentively and devotedly cared for by his mother who has rarely if ever left him out of her sight. In the film we first see a lively, active, curious little boy with his mother and father, busily exploring the room, running to and from his parents. When both parents leave the room there is an immediate, frantic, tearful response, running toward the door, reaching for the knob, crying loudly. This is unabated until the mother and father return some few minutes later, at which point he runs past the father to the mother, reaching out his arms to be picked up. Although looking somewhat somber, he is immediately comforted in the mother's arms. The next scene demonstrates the child 24 hours later, having been left in the hospital by the parents whom he has not seen since. The child is seated in the crib, his left hand holding a bar. He is almost completely immobile, his face is impassive, lip corners turned down, and a sad expression

continued on next page

around the eyes. The entry of a doctor whom he has known evokes little response, only a slight turning of the head, but no vocalization. When the child is now lifted off the crib on to the ground he is not only unsteady on his feet but walks with a shaky gait, slow, mincing steps, and maintains his left arm and hand in the same fixed position, as if still holding the crib bar. He finally slowly walks to a chair and steadies himself with the left hand. When lifted up by the doctor he remains quiet and leans against him. This striking behavioral change within 24 hours is interpreted as a depressive response to object loss, specifically to the loss of his parents, his siblings, his grandparents, and his familiar home surroundings. We can't know what the child feels. He seems overwhelmed, lost, in despair, helpless. The third scene shows the child three weeks later after recovery from a surgical repair and ready to be discharged from the hospital. His parents have visited daily, stayed with him several hours at a time. The appearance now is of even greater retardation and immobility than before. However, when picked up by the doctor, who has also seen him several times daily, he relaxes somewhat in his arms, though remaining relatively inactive. When the mother enters the room he immediately reaches toward her with his arms and whole body. However, when held by the mother now he pulls away and cries vigorously. She is unsuccessful in comforting him for the first several minutes. This demonstrates the continuing impact of the repeated coming and going of the mother and the significant change that has taken place, not only in his over-all behavior pattern but in his mode of relating to the mother. Additional information not recorded in the motion pictures revealed that the child remained fretful, easily upset, and extremely intolerant of having the mother leave, a situation which persisted for a number of weeks.

The second part of the movie shows a somewhat different kind of situation. This concerns a little girl, also born with congenital atresia of the esophagus and having a surgically produced gastrostomy. This case is described in detail elsewhere.[13] After being cared for by both mother and grandmother for the first six months, circumstances required that the mother, with another small child, separate from her own parents and live with her psychopath husband in an isolated area distant from her own family. Depressed over this separation and again pregnant, she had serious problems in her ability to accept and relate to her defective child. As a result there were long periods during which the little girl was neither held nor comforted and cried herself to exhaustion. In this setting, in spite of adequate caloric intake via the gastric tube, she not only failed to gain weight or develop further, but even lost so that at 15 months, the time of first recording in the movie, she weighed only 10 pounds, was unable to sit up, and presented the appearance of marked marasmus and depression. The movie illustrates this first state which was categorized as a severe depression of infancy. After five months of attentive care, particularly by one nurse and one physician, the child showed a marked improvement, gaining weight, becoming responsive, attentive, and manifesting a full range of responsive behavior with pleasant, joyful recognition of both nurse and doctor. The old depressive behavior, however, was easily reproduced whenever she was approached alone by a stranger. This was in contrast to the more usual and expected anxiety pattern observed in children of this age and stage of development. The pattern included not only a profound immobility and hypotonia, the tendency to fall asleep, but also a marked reduction in gastric secretion, which even became unresponsive to histamine.[14] The movie also illustrates her immediate behavioral response and recovery on the return of the familiar doctor and how when the stranger comes with the familiar doctor he quickly becomes associated with him and loses the capacity to provoke this depressive withdrawal response.

This second part of the movie provides evidence that a depressive type of response can develop in the presence of an object when the relationship is ineffective and further that this response can become a fixed pattern ready to be re-evoked under certain circumstances. The study also demonstrates certain significant biologic changes accompanying this state.

The movie clearly provides a graphic and, I hope, convincing demonstration of the reality of the phenomenon under consideration. Spitz has amply documented the occurrence of such reactions among infants and has further described under the term "hospitalism" the profound retardation in development which takes place when infants are brought up after the third month in a sterile environment with relatively few human contacts.[15,16] The "hospitalism" group suffered an unusually high mortality from infectious diseases. The whole field of the impact of early separations and deprivations among infants and small children is now the subject of wide interest.[17]

What further is known of the consequences of object loss when it is followed by giving up and the affects of helplessness and hopelessness in adults? Here we are just at the beginning of exciting new insights. Over the past 15 years there have been scattered allusions to the possible significance of

losses, grief, depression, and so on, as precipitating or conditioning circumstances for the development of or exacerbation of certain specific diseases such as diabetes, tuberculosis, and thyrotoxicosis.[12] But when unselected populations of medical patients were studied carefully from this point of view this relationship was found to hold true in a number of conditions, such as leukemia, in which no hint of such factors had previously been guessed.[18] Schmale finally studied a large series of unselected medical patients, the typical population found on the medical ward of a general hospital, and discovered a very high incidence of unresolved object loss, approaching 80 per cent, as an antecedent event preceding the development or exacerbation of the illness.[12] Wolfe, Hinkle, and their associates, using a different approach and somewhat different terminology, have been led to a similar conclusion, namely that the state of giving up with its corresponding affects may be the psychological reflection of a more profound alteration in total biological function which serves to alter the capacity of the organism to resist or compensate for factors leading to disease.[19]

Reports on the consequences of certain major social disasters seem to provide some support for this view. Most notable, of course, was the appalling morbidity and mortality among the American prisoners of war during the Korean war. With the destruction of morale and the marked dissolution of the pre-existing social supporting organization, the syndrome "give-up-itis" came to be recognized as an ominous prelude to serious illness and death. Further, it was noted that some soldiers could be saved if they could be stimulated into some kind of relationship, even an angry one, with a fellow soldier. In sharp contrast was the low morbidity and mortality among the Turkish volunteers who for various reasons were able to maintain morale in highly effective interpersonal relationships.[20] Such reports are but more accurate and well-documented accounts of what has long been known among prisoners of war, concentration camp victims, victims of disasters, transported slaves, and similar groups. H. Wolff has recently summarized some of these observations.[21] In parallel with this are the fascinating autobiographical accounts of remarkable individuals who have survived such experiences. Striking through all such accounts that I have read is the extraordinary capacity of the individual not only to serve as an object for himself but also to be able to call upon his memory as an almost unending source of nutriment. Important, too, have been firmly held political or religious ideals or beliefs.

Such reports and observations can only whet our appetites for more precise information. Naturally it is tempting to turn to the experimental laboratory and animals. Here, too, even preliminary studies are already rewarding. That animals exhibit grief reactions is well established and certainly well known by pet owners. Clearly there is a readily available source of experimental material for the investigation of biologic, biochemical, and physiologic aspects of these reactions. The effects of early or previous experience on the susceptibility to disease is already the subject of a growing literature. Time permits me to cite only a few observations. For example, it has been shown that the incidence of spontaneously developing mammary tumors in certain strains of mice is greater in animals living alone than in those living in cages with other animals.[22,23] A recent series of studies has shown that the susceptibility to gastric ulcers developing in rats placed in a conflict situation is influenced by whether the animal is alone or in the company of one or two other animals, animals in the latter situation being the more resistant.[24] Ader, using the same technique but a strain of rats more susceptible to ulcer formation, failed to substantiate this protective effect in the paired situation, but considered that the effect may have been masked by the greater susceptibility.[25] However, he was able to demonstrate a significant effect of the age at which the infant rats were separated from their mothers on susceptibility to ulcer formation in adulthood. Thus, animals separated from their mothers at 15 days of age were significantly more susceptible than were those separated at 22 days (normal weaning time) and at 35 days. On the other hand, animals that had interrupted separations during the first 10 days of life (in contrast to the permanent separation at 15 days) were significantly more resistant than were the normally weaned animals.[26] In other words, permanent early separation and interrupted early separations have opposite effects on the later susceptibility of rats to ulcer formation when exposed to a conflict situation in adult life. That the increase in the susceptibilty of infant rats separated at 15 days is not due to a nutritional deficit was demonstrated by showing that rats raised by a mother whose nipples were cauterized at 15 days were as resistant as the control (22-day) rats.[27] Using a different condition, namely susceptibility to alloxan diabetes, as a dependent variable, preliminary data indicate that rats caged in groups of eight are more susceptible to the hyperglycemic effect of alloxan than are animals caged individually.[28] Paired animals, on the other hand, appeared to be more resistant than either animals alone or animals in groups of eight. Another interesting finding has been reported by Groen.[29] Hamsters are ordinarily gregarious animals and when caged together exhibit considerable body contact. However, if a female hamster is successfully mated and then the mate removed and replaced by a strange male, the female will adopt a belligerent, threaten-

continued on next page

ing attitude, forcing the male to maintain distance and a defensive posture. After some period in this situation the male so isolated and threatened becomes manifestly ill and some die. The autopsy reveals primary amyloid disease.

Such studies strongly suggest that the nature of both early and current social relationships among animals are variables in the susceptibility to disease which can be studied in the laboratory. The preliminary results from a number of different laboratories indicate that the nature of the early life experiences exert significant effects on the mode and success of the responses to later life experiences, helping to determine what will constitute a stress and the capacity of the animal to deal with it. Biologic factors, on the other hand, determine the nature of the organic defects which evolve under such circumstances. Thus, in rats subjected to physical restraint significant variables underlying the susceptibility to erosions in the body of the stomach include strain, sex, and the level of plasma pepsinogen.[30] Surely here is an enormous field for future research, not only in respect to the further elucidation of the role of such factors in disease, but also in respect to the discovery of the biochemical and physiological processes involved.

Whether we concern ourselves with man or with animals, what is engaging our attention is the significance of the internalized (learned, if you will) aspects of the environment which serve regulatory functions for the organism. What we have designated as object loss is essentially some change in the "fit" between this internalized environment and the real external environment. Most times this is brought about by a change in the environment, as occurs with a death or separation. It may also come about, as psychoanalytic studies have amply demonstrated, from internal, psychologic changes, so that the environment seems different, as in a phantasied loss. In either situation, however, it is well to emphasize that we are identifying a ubiquitous *psychological stress*, meaning that the concept of objects and of object loss is meaningful mainly in terms of the existence and operation of a mental apparatus. This means that whatever the consequences may be of object loss, whether manifest ultimately in biochemical, physiological, or social terms, the change in the environment must first have been perceived and apperceived and the consequences mediated by the central nervous system. This imposes upon us the necessity to pay more attention to the role of the central nervous system in the maintenance of the functional integrity of the organism as a whole as well as of its parts. This has been a much neglected field which is now beginning to attract much interest. Stewart Wolf, in his Minot Lecture of 1959, reviews some of our current knowledge in this area.[31]

And finally we come back to the implications of these developments for the care of the patient. We are proposing that the mysterious ingredient, the powerful therapeutic influence of the physician, the hospital, the clinic, the placebo (not to mention nonmedical or paramedical healing influences) is none other than the effect of a substitute object. When to the high frequency with which illness is preceded, if not precipitated, by object loss, real, threatened, or phantasied, and depression, we add the fact that any illness and disability may also provoke object loss secondarily, the potential importance of object replacement becomes obvious. Some years ago I suggested that the doctor may be seen as fulfilling "a surrogate ego role" for the patient.[32] This is perhaps but another way of formulating the processes discussed in this paper, since we now recognize the role of object relations in developing ego function and can understand better how object loss may bring about ego regression. Whether the physician operates as a "surrogate ego" or whether he serves as an object and thereby brings about more effective ego function is less important than our recognition that doctor-patient relationship can be a key factor in bringing about the mental and emotional stabilization of the patient. It is of interest that the word "confidence" describes the affective state most representative of the optimal conditions for survival and growth both of the child in relation to his mother and the patient in relation to his physician. Obviously, confidence alone is not enough, for, as we well know, confidence may be misplaced, in physician as well as in mother. However, this is not the place to elaborate on the subtleties of the factors underlying the nature of the relationship of physician and patient which psychoanalysis has elaborated in terms of the transference and countertransference. Rather, we wish to emphasize the significance of the physician successfully fulfilling the role of object for the patient.

From all this the conclusion seems inescapable. The humane, understanding care of the patient, in all its aspects, whether it be how the doctor, the nurse, or the attendant behaves, how the hospital is run, how the operating room or radiology department functions, all must have a rational scientific basis. That which is humane is humane because it takes into account the scientific bases underlying human relationships, especially in the object-relating aspects discussed in this paper. When the humane is based on maudlin sentimentality, on "do-goodism," on the principles of public relations or advertising, on sympathy rather than empathy,[33] then it may as often deviate from as coincide with a sound scientific basis, in which event it may have, for certain patients, disastrous consequences.

May I close with the warning that the major

thesis of this paper is far from proven. It is, to some of us at least, highly suggestive and certainly exciting. If I have provoked a few of you to think more critically of these matters, to seek new approaches to their investigation, and particularly to try to prove me wrong, I shall feel my time well spent. If I have convinced any of you that the case is proven, I shall regard that only as evidence that I am more silver-tongued than I am a scientist and I shall be chastened. But I do hope I have convinced you of the pertinence of John Romano's warning that the present problems of medicine are not that it has become too scientific, as some who decry the loss of humanism claim, but that it has not yet become scientific enough.[2]

References

[1]Dubos, R.: Mirage of Health. New York, Harper, 1959

[2]Romano, J.: Basic Orientation and Education of the Medical Student. J.A.M.A. 143:409, 1950

[3]Engel, G. L.: Homeostasis, Behavioral Adjustment and the Concept of Health and Disease, in Mid-Century Psychiatry, R. Grinker (ed.), pp. 33-59, Springfield, Ill., Charles C. Thomas, 1953

[4]Engel, G. L.: A Unified Concept of Health and Disease. Perspectives in Biology and Medicine 3:459-485, Summer, 1960

[5]Shimkin, M. B., in Cancer, R. W. Raven (ed.), p. 162, London: Butterworth and Co., 1952

[6]Rapaport, D.: The Theory of Ego Autonomy: A Generalization. Bull. Menninger Clinic 22:13, 1958

[7]Piaget, J.: The Construction of Reality in the Child (1937), New York, Basic Books, 1954

[8]Kowal, S. J.: Emotions as a Cause of Cancer. The Psychoanal. Review 42:217, 1955

[9]Kowal, S. J.: Emotions and Angina Pectoris. American Journal of Cardiology 5:421, 1960

[10]John, E. R.: Some Speculations on the Psychophysiology of Mind, in Toward a Definition of Mind, J. Scher (ed.), Free Press, 1960

[11]Engel, G. L.: Is Grief a Disease? A Challenge for Medical Research. Psychosom. Med., in press

[12]Schmale, A. H., Jr.: Relationship of Separation and Depression to Disease. Psychosom. Med. 20:259, 1958

[13]Engel, G. L., and Reichsman, F.: Spontaneous and Experimentally Induced Depressions in an Infant with a Gastric Fistula. J. Am. Psychoanal. Assn. 4:428, 1956

[14]Engel, G. L.; Reichsman, F., and Segal, H. L.: A Study of an Infant with Gastric Fistula. Psychosom. Med. 18: 374, 1956

[15]Spitz, R. A.: Hospitalism. The Psychoanalytic Study of the Child 1:53-74, New York, International Universities Press, 1945

[16]Spitz, R. A.: Anaclitic Depression. The Psychoanalytic Study of the Child 2:313-342, New York, International Universities Press, 1946

[17]Bowlby, J.: The Nature of the Child's Tie to His Mother. The International J. Psycho-Anal. 39:1, 1958

[18]Greene, W. A., Jr., and Miller, G.: Psychological Factors and Reticuloendothelial Disease. IV. Observations on a Group of Children and Adolescents with Leukemia: An Interpretation of Disease Development in Terms of the Mother-Child Unit. Psychosom. Med. 20:2, 1958

[19]Hinkle, L. E., and Wolfe, H. G.: Ecological Investigations of Relationship Between Illness, Life Experience and Social Environment. Ann. Int. Med. 49:1373, 1958

[20]Kinkead, E.: In Every War But One, New York, W. W. Norton, 1959

[21]Wolff, H. G.: The Mind-Body Relationship, in An Outline of Man's Knowledge, Doubleday, 1960. Lyman Bryce (ed.)

[22]Andervont, H. B.: Influence of Environment on Mammary Cancer in Mice. J. Nat. Cancer Inst. 4:579, 1944

[23]Muhlbock, O. F. E.: Invlaed van bet millieu af de kunkerontwikkeling. Onderzalkinger by de melkklierkanker van de muis. Ned. Tydschr. v Geneesk, 94:3747, 1950

[24]Sawrey, W. L.; Conger, J. J., and Turrell, E. S.: An Experimental Investigation of the Role of Psychological Factors in the Production of Gastric Ulcers in Rats. J. Comp. Physiol. Psychol. 49:457, 1956

Sawrey, W. L., and Weisz, J. D.: An Experimental Method of Producing Gastric Ulcers. J. Comp. Physiol. Psychol. 49:269, 1956

[25]Ader, R.; Beels, C. C., and Tatum, R.: Social Factors Affecting Emotionality and Resistance to Disease in Animals: I. Age of Separation from the Mother and Susceptibility to Gastric Ulcers in the Rat. J. Comp. Physiol. Psychol. 53:446, 1960

[26]Ader, R.; Beels, C. C., and Tatum, R.: Social Factors Affecting Emotionality and Resistance to Disease in Animals: II. Susceptibility to Gastric Ulceration as a Function of Interruptions in Social Interactions and the Time at which They Occur. J. Comp. Physiol. Psychol. 53:455, 1960

[27]Ader, R.: Social Factors Affecting Emotionality and Resistance to Disease in Animals: III. Early Weaning and Susceptibility to Gastric Ulcers in the Rat; A Control for Nutritional Factors. In preparation

[28]Ader, R., and Jacobs, H. L.: Social Factors Affecting Emotionality and Resistance to Disease in Animals: III. Reactions to Alloxan in Group and Individually Caged Rats. To be published

[29]Groen, J. J.: Personal communications

[30]Ader, R.; Beels, C. C., and Tatum, R.: Blood Pepsinogen and Gastric Erosions in the Rat. Psychosom. Med. 22:1, 1960

[31]Wolf, S.: Neural Integration and the Mechanisms of Disease. Minot Lecture to the Section on Internal Medicine of the American Medical Association, Atlantic City, June 9, 1959

[32]Engel, G. L.: The Surrogate Ego Role of the Physician in the Management of Physically Sick Patients. Presented at a Round Table Discussion of Psychotherapy in Medical and Surgical Hospitals, Mid-Winter Meeting, American Psychoanalytic Association, New York, December 8, 1951

[33]Engel, G. L.: Affects in Terms of Drive, Ego, and Self-Object. A Developmental Perspective. To be published

J. E. BRENNAN & COMPANY

Leo C. Clark, Jr., B.S., Reg. Pharm.

Apothecaries

Two Convenient Locations

5 North Union Street — Pawtucket, R. I.

140 Central Avenue — Seekonk, Mass.

7 Registered Pharmacists

Pharmacy License #226

NECK INJURY AND REAR-END COLLISION

THOMAS C. MCOSKER, M.D.

The Author. *Thomas C. McOsker, M.D., of Providence, Rhode Island. Associate Neurosurgeon, Rhode Island Hospital.*

IN THE VIOLENT traffic-filled world of today, neck injuries are becoming more common. Over the past several years there has been a growing incidence of the so-called whiplash injury. In this paper, however, the term whiplash has been deliberately eschewed and neck strain substituted. Our powerful modern cars, with their paucity of safety features, combined with the multiplicity of traffic lights and left-hand turns from high speed roads, have produced many rear-end collisions. Considerable force is applied to a motionless but movable object. As the auto moves forward, the passenger's head stays in place due to inertia, the individual's thorax is moved forward, the neck snaps backwards and then the whole body is thrown forward.

Since casualty insurance is carried by most drivers there are inevitable legal complications. In such cases it is the practice of insurance companies to require examination by a doctor other than the attending physician. This is done when the patient is still having symptoms, or at least before settlement. A large file of cases referred for such evaluation has accumulated in this office. In each case a general history, past history, and physical examination is done and the findings recorded in a standard manner. Particular attention is directed to the head and neck, and to the appropriate neurological examination.

Gotten[1] and others studied this problem in 1956 by following up 100 patients who had settled their legal cases and found 54 per cent had no symptoms and only 12 per cent were taking any treatment.

One thousand records of individuals having neck injuries, rear-end collisions, or both were recently reviewed. These cases were examined between 1946 and 1960, but the greater numbers have been seen since 1953. One thousand was used as a convenient stopping place, but there are many more available. Virtually all were seen only once, but in most the attending physician was consulted for his findings and results of X-rays. Of these, 759 were seen between 3 and 12 weeks after injury, the largest number being seen 6 weeks after injury. At the extremes, 14 were seen within one week and 8 were seen more than 2½ years following the injury.

Of the 1000 cases, 712 were involved in rear-end collisions, and 540 or 75.8 per cent of these had neck symptoms. Another 251 suffered neck injury from various industrial accidents or in auto accidents in which the blow to the car came from neither the front or back. The remaining 37 patients were involved in front-end collisions with resultant neck symptoms. Since the cases were taken consecutively from my files, it would seem that front-end collision is not a great cause of neck symptoms (Figure 1).

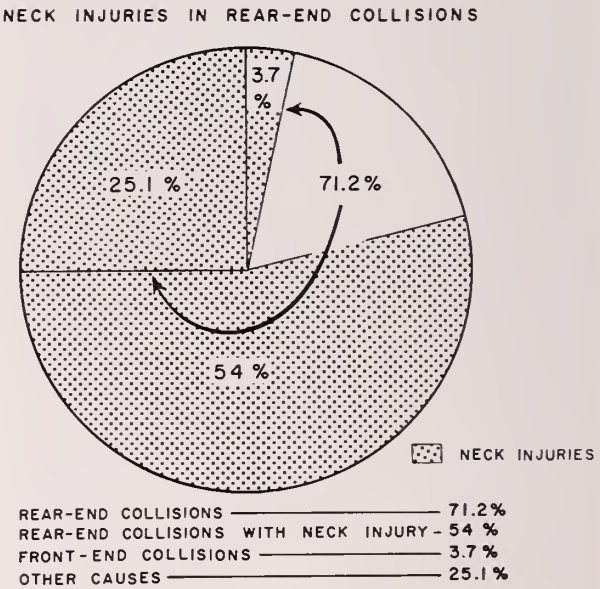


FIGURE 1

A total of 828 cases therefore had some neck symptoms. Large numbers of these had radiation of pain into the arms or up into the head. An attempt was made to differentiate between the pain due to direct trauma and that due to radiation of pain from the neck (Figure 2).

The head symptoms from neck injury consist of occipital pain with some further radiation into the forehead, eyes, or ears. This pain arises from the upper cervical nerves. Although this discomfort can be modified by anxiety, the syndrome is readily recognizable. Of the neck pain group 250 or 30.2

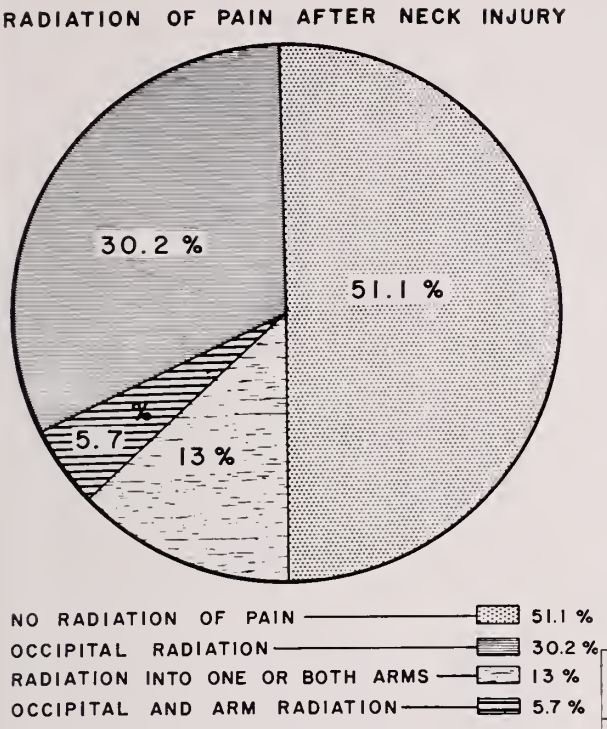


FIGURE 2

per cent had radiating occipital pain.

Similarly, arm pain from neck strain comes from the lower cervical nerves and typically causes paraesthesias which are often quite discrete and limited to dermatomes. Some 108 or 13 per cent had definite paraesthesias and pain extending into one or both arms.

However, only 47 or 5.7 per cent of the 828 cases had pain radiating both ways. This comparatively small percentage who had pain in both head and arm suggests that the injury tends to be localized in either the upper or lower portion of the neck and that it is comparatively rare for the whole cervical spine to be injured.

Adding the figures, it is noted that 405 or 49 per cent of individuals with neck pain from trauma had radiation of pain. Less than 3 per cent of the people involved in rear-end collisions and having no neck pain did have occipital pain. None had arm pain.

Except in a few cases, X-rays were not obtained at the examination but reports were sought in all who stated that X-rays were taken. Of the neck injured group 505 or 61 per cent had films taken of the cervical spine. Of those X-rayed 73 or 14.4 per cent were said to have some evidence of osteoarthritis. Other than that rather common pathological finding, there were only 9 cases showing definite abnormalities. There were three ruptured discs, reported on myelographic evidence, and only one of these occurred in an individual struck from the rear. One fracture, described as a minimal compression of the anterior edge of C5, was noted in a person struck from the rear, but it is noteworthy that the patient was treated very conservatively. There were five reports of slight subluxation, of which two were described as doubtful. Two of these followed rear-end collisions, one was in a patient involved in a front-end collision, and the other two occurred after industrial accidents involving falls. It is therefore evident that damage to the bony structure of the neck in rear-end collisions is extremely rare.

Nagle[2] in 1957 stated that fractures were encountered in "whiplash" injuries and that these were of the lateral masses and processes usually. However, Zatzkin and Kveton[3] reviewed 50 cases exhaustively and found no fractures or dislocations.

In the physical examination, tenderness or limitation of the motion of the neck, objective spasm, and neurological signs were especially noted. The reflexes were elicited and sensation was mapped with pinprick and light touch (Figure 3).

SYMPTOMS	712 PATIENTS IN REAR-END COLLISIONS	252 PATIENTS WITH NECK PAIN WITHOUT REAR-END COLLISIONS
LIMITATION OR TENDERNESS	44.8 %	64.9 %
SPASM	7.6 %	10.8 %
NEUROLOGICAL CHANGES	3.4 %	5.4 %

FIGURE 3

Of those 712 individuals who were involved in rear-end collisions, 319 or 44.8 per cent had either limitation of motion or some tenderness in the neck. Some of these may have been voluntary, but it was constant throughout the examination.

Only 54 or 7.6 per cent had true spasm, consisting of constant palpable tension of the neck muscles. 24 or 3.4 per cent had changes in reflexes or sensory changes. Those patients who had only paraesthesias were not included. It is noteworthy that the majority of cases had only subjective findings.

When the 251 records of those who had neck pain but were not involved in a rear-end collision are reviewed, somewhat similar figures are obtained. Of these, 163 or 64.9 per cent had limitation or tenderness, 27 or 10.8 per cent had spasm, and 14 or 5.6 per cent had neurological signs.

Of the 37 persons involved in front-end collisions, 26 or 70 per cent had limitation of motion, 4 or 11 per cent had spasm, and there were no objective neurological signs noted.

A high percentage of patients do not experience

continued on next page

neck pain for several hours after the accident. In the rear-end collisions group 324 or 45.5 per cent had immediate discomfort, and 133 or 53 per cent of those who had sundry other accidents to the neck had immediate pain. About half of the patients therefore will have no neck symptoms directly after the accident.

In this study particular attention was paid to the neck, but it became apparent that many people had associated back pain. Again referring to the 712 who were in autos struck from behind, 76 or 10.7 per cent had only back injury. This was usually located in the mid-back. Low back pain seemed to be limited to those who had had low back symptoms before the accident. A total of 200 or 28 per cent had both back and neck symptoms. Almost exactly the same percentage, 28.5 per cent of the 251 who had neck pain from other causes, had back pain also.

Head injuries in these groups were common but were generally minor in nature, 211 or 29 per cent of the rear-end collision group having had head injuries, while 109 or 37.8 per cent of the other group sustained trauma to the head (Figure 4).

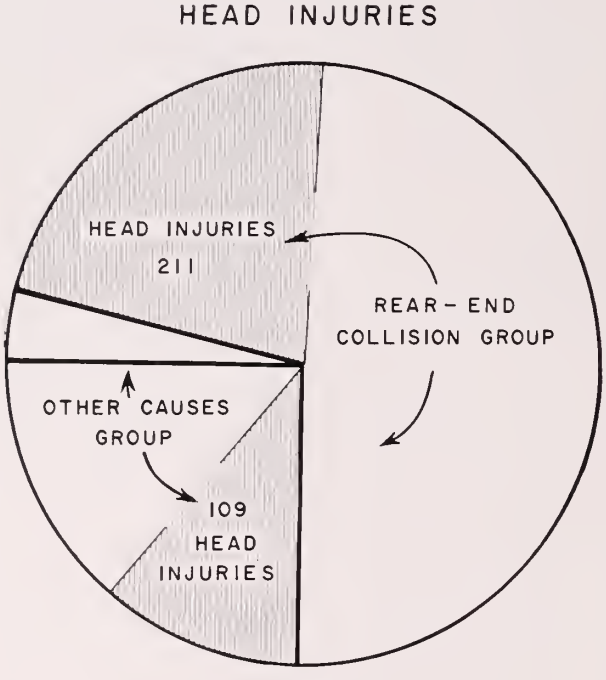


FIGURE 4

When the head strikes an object, however, the strain on the neck evidently tends to be less. Of the 540 individuals who were in rear-end collisions and had neck symptoms, 139 or 25.7 per cent had head injuries. Of the 172 in similar collisions who had no neck symptoms, 72 or 41.8 per cent had head injuries (Figure 5).

In both groups there were miscellaneous injuries to other parts of the body, with the chest and knees being the most involved. These injuries were usu-

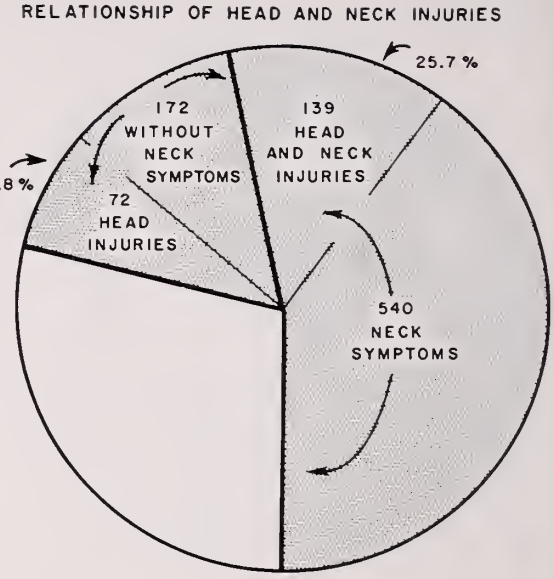


FIGURE 5

ally of a minor nature. It is common for individuals who were hit from behind to complain almost immediately of chest pain, but this complaint disappears long before the neck symptoms go.

Children seem to make up a special group. There were 42 children who were involved in rear-end collisions, and 59 per cent of them had no symptoms of neck injury at any time. Those with symptoms had no spasm, or sensory or reflex changes. Two children were seen who injured their necks in falls. Both had limitation and tenderness in the neck, but no objective signs.

SUMMARY

Traumatic neck strain is an extremely common condition. About three quarters of the patients who are injured in rear-end collisions have symptoms referable to the neck. Furthermore, an extremely low percentage of these individuals will have any X-ray evidence of injury to the bony structure of the neck. Although the greater number will have symptoms of pain in either arms or head, presumably due to stretching or contusing of the cervical roots, few will show objective changes. Comparison of those who were injured in rear-end collisions with those with neck injuries from various other causes shows few points of difference. The so-called whiplash injury appears to be very similar to any other type of neck strain. In rear-end collisions, almost any portion of the spine can be the point of greatest injury, and in most cases there is one major point of injury. This is shown by the relative paucity of cases who had symptoms referable to more than one place in the spine. Neck injury is comparatively rare in front-end collisions. Traumatic neck strain is found to be a painful and annoying disorder which can cause symptoms for a

concluded on page 257

SPONTANEOUS RUPTURE OF THE NORMAL SPLEEN

A Case Report

ORLAND F. SMITH, M.D.; MAURICIO RODRIGUEZ, M.D., AND JAMES W. MEADE, M.D.

The Authors. *Orland F. Smith, M.D., Surgeon-in-Chief, Memorial Hospital, Pawtucket, Rhode Island.; Clinical Instructor in Surgery, Boston University School of Medicine, Boston, Massachusetts.*

Mauricio Rodriguez, M.D., Senior Resident in Surgery, Memorial Hospital, Pawtucket, Rhode Island.

James W. Meade, M.D., Senior Resident in Surgery, Boston University Surgical Service, Boston City Hospital, Boston, Massachusetts.

SPONTANEOUS RUPTURE of the pathological spleen is a well-recognized clinical entity. Rupture of the normal spleen without trauma has been reported in 31 cases but some observers feel that such a situation does not exist. Such instances as have been reported are felt to be due to poor history taking, or to the faulty memory of the patient.[1] Whether this is true or not, it should be recognized that hemoperitoneum from rupture of the spleen may present itself without any evidence of history of injury.

Orloff and Peskin, in 1958, reviewed the world's literature on the subject, and found a total of 71 cases.[2] Of these, only 20 fulfilled the strict criteria of spontaneous rupture. Eight more cases were noted as borderline, and they included one of their own experience, making 29. Since 1959 there have been two more cases reported and one case was included in Jung's article on traumatic rupture.[1,3,4] This brings the total to 32 cases. All of these fulfilled the criteria of no history of trauma, no evidence of old injury such as perisplenic adhesions and normal histology.

The clinical features of spontaneous rupture of the spleen are the same as those noted with trauma. Upper abdominal pain, usually in the left upper quadrant, positive Kehr's sign, nausea and vomiting, and signs of acute anemia were usually present. In spite of this, the correct diagnosis has been made only twice in the above-mentioned cases.

Pathologically, rupture of a subcapsular hematoma represented more than 50 per cent of the cases in which the type of injury was noted. The remainder demonstrated intrasplenic hematomata, laceration into the parenchyma, and fragmentation. Otherwise the spleen was normal.

No satisfactory explanation has been given for this condition. Among the theories advanced are spasm of the splenic vein, portal congestion, localized disease destroyed by the rupture, torsion of the splenic pedicle, rupture of the arteries due to degenerative changes, and unnoticed trauma.[2] A number of cases have been associated with increased intra-abdominal pressure. Pregnancy, lifting, violent coughing defecation and vomiting have been noted in some cases to have preceded spontaneous rupture. We have observed and treated a case which occurred after a fit of severe coughing.

A fifty-eight-year-old white male was admitted to the hospital because of dyspnea and pain in the left upper quadrant of the abdomen. Patient became ill about eight days prior to his admission with anorexia, generalized malaise, and weakness. The day before admission, his condition worsened when he became short of breath and complained of nausea and pain in the left side of the abdomen after violent coughing. Patient suffered from chronic emphysema. He denied any trauma and is not an alcoholic or epileptic.

Physical examination revealed a well-developed and fairly well-nourished and dyspneic patient complaining of abdominal pain. The main physical findings were: blood pressure 72/40, pulse 130, temperature 97.4, tachycardia, no murmurs; lungs, crepitant rales in both bases more marked on the left; abdomen was distended, soft, tender in left upper quadrant and left flank with muscular spasm in these areas, tenderness to percussion in the left lumbar area, no peristalsis, no palpable masses; rectal examination showed a normal tonicity of sphincter, no masses and no tenderness. The rest of the physical examination was unremarkable.

On admission, white blood count was 42,100 per ml. with 89 per cent polymorphonuclear leucocytes, 4 per cent stabs, Hemoglobin 11.1 grams per ml. Hematocrit 33 per cent. Amylase 8 units, Urinary diastase 128 units (normal 8-32). Chest X-ray showed atelectasis of the left base. Flat plate of the abdomen was consistent with paralytic ileus.

Twelve hours after admission, hemoglobin was 9.6 grams per ml., hematocrit 27 per cent. Patient was transfused with two units of blood and blood pressure went up to 120/80 with pulse around 100 per minute.

concluded on page 257

A STUDY OF OBSTETRICS AND GYNECOLOGY

A Report Prepared by the National Disease and Therapeutic Index and Distributed by Lea Associates, Inc., Flourtown, Pennsylvania

The Sample

THIS REPORT, the fourth in a series on different branches of private medical practice, focuses on the specialty of *Obstetrics-Gynecology*. In presenting a profile of the specialist's practice, told in certain statistical facts, appropriate comparisons are made with general practitioners and with all doctors.

As of January 1962, American Medical Association records list 10,477 doctors engaged in the full-time specialty of obstetrics-gynecology; the term "full-time" is defined as limiting the doctor exclusively to the area of his specialization. On a percentage basis, these specialists account for slightly more than 6 per cent of all doctors in private practice.

Figures in the following report are based upon 9,472 N.D.T.I. patient-doctor contacts involving obstetricians-gynecologists during 1960.

Patient Load

Obstetricians-gynecologists see an average of 18.7 patients per work day. The average for general practitioners is 22.1 per work day, for all doctors, 19.4 patients.

PERCENTAGE OF PATIENTS SEEN BY LOCATION

	OBG.	GP	All MDs
Office	75%	77%	78%
Hospital	21	13	15
Home	1	7	4
Other	3	3	3
	100%	100%	100%

Hospital visits accounted for one fifth (21%) of total patient-doctor contacts in the obstetrician-gynecologist group; this was only slightly lower than the share for internists (22%). General practitioners saw about one seventh (13%) of their patients at the hospital.

PERCENTAGE OF PATIENTS SEEN BY SEX

	OBG.	GP	All MDs
Male	5%	41%	40%
Female	95	59	60
	100%	100%	100%

Although women had the overwhelming share of visits to obstetricians-gynecologists, men accounted for a surprisingly large proportion (5%) of visits involving these specialists.

Note that females accounted for a majority of patient-doctor contacts for general practitioners and All Mds in private practice.

PERCENTAGE OF PATIENTS SEEN BY AGE GROUP

	OBG.	GP	All MDs
Under 10 Years	4%	20%	20%
10-19 Years	8	11	10
20-39 Years	69	27	28
40-59 Years	15	22	24
Over 59 Years	4	20	18
	100%	100%	100%

About 7 out of 10 contacts with obstetricians-gynecologists involve patients in the 20- 39-year "child birth" age group. This is more than twice the proportion of patients for general practitioners or for All MDs in this age group.

NUMBER OF DIAGNOSES PER PATIENT

	OBG.	GP	All MDs
One diagnosis	91%	85%	85%
Two diagnoses	8	13	13
Three or more diagnoses	1	2	2
	100%	100%	100%

Multiple diagnoses are relatively rare among obstetricians-gynecologists. Their incidence is nearly twice as great among general practitioners as among obstetrics-gynecology specialists.

PERCENTAGE OF REFERRED PATIENTS

	OBG.	GP	All MDs
Referred from other Mds	15%	4%	18%
Non-referred	85	96	82
	100%	100%	100%

The table above indicates that one patient in seven who consults an obstetrician-gynecologist has already seen another doctor (probably a general practitioner) regarding the condition; this rate

drops to one patient in 25 for general practitioners.

The percentage of patients referred for the various types of specialists ranges from 12% for pediatricians to 68% for urologists.

PERCENTAGE OF PATIENT VISITS WITH SURGERY

	OBG.	GP	All MDs
Surgery	6%	3%	4%
Non-surgery	94	97	96
	100%	100%	100%

Some type of surgery is performed during 6% of patient-doctor contacts involving obstetricians-gynecologists. Such surgical procedures may be performed in the doctor's office or in the hospital.

Among surgeons, the proportion of visits when surgery is performed is only slightly higher (9%).

* * *

The table following ranks leading diagnoses treated by obstetricians-gynecologists. (Diagnosis classifications used are those established by the World Health Organization.) The rates shown represent the number of times each diagnosis occurs in every 1,000 doctor-patient contacts.

Normal prenatal and post-partum care are the two leading conditions, accounting for more than one third of the patient visits. The prominence of these diagnoses is accentuated by the considerably lower rate of the third-ranking diagnosis.

LEADING DIAGNOSES TREATED BY OBSTETRICIANS-GYNECOLOGISTS

Diagnosis	Rate 1,000 Visits (All Diagnoses)
Prenatal care	278
Post-partum care	110
Complications of pregnancy[1]	49
Medical/surgical aftercare	42
Menstrual disorders[2]	39
Cervicitis, vaginitis, vulvitis	31
General medical examination	26
Delivery without complication	22
Menopausal symptoms	21
Benign neoplasm of uterus[3]	15
Obesity, non-endocrine	13
Follow-up examination, other	13
Prophylactic inoculation/vaccination	12
Acute URI	9
Sterility, female	9

[1]Includes threatened abortion, anemia, hyperemesis gravidarum, G-U infection.

[2]Includes menorrhagia, intermenstrual bleeding, PMT, dysmenorrhea, amenorrhea.

[3]Includes uterine fibromyoma.

SPONTANEOUS RUPTURE OF THE NORMAL SPLEEN

concluded from page 255

In spite of the blood transfusion, the following day the hemoglobin was 8.3 grams per ml. and hematocrit 25 per cent. The abdomen was distended, tender in the left upper quadrant and left flank. Patient was transfused with three units of blood, but hemoglobin and hematocrit remained unchanged. No blood was obtained from the stomach or rectum. The abdomen was distended, tender all over, more in the left side. In spite of transfusions, hemoglobin was 7.8 grams per ml. and hematocrit 27 per cent.

Exploratory laparotomy was decided upon. After blood transfusion, the patient was taken to the operating room. Upon exploration 3500 ml. of blood were found in the peritoneal cavity. The spleen was normal in size but lacerated. Splenectomy was carried out. Pathological report showed a normal spleen with chronic perisplenitis.

Patient had an uneventful postoperative course and was discharged on the tenth postoperative day.

References

[1]Husni, E. A., and Turell, D.: Spontaneous Rupture of the Normal Spleen. Arch. Surg. 83:286, 1961

[2]Orloff, M. J., and Peskin, G. W.: Spontaneous Rupture of the Normal Spleen. Int. Abst. Surg. 106:1, 1961

[3]Perl, J. I.; Darter, R. W., and Milles, G.: Spontaneous Rupture of the Normal Spleen: Report of a case. J. Int. Coll. Surg. 30:420, 1958

[4]Jung, O. S.; Cammack, K. V.; Dodds, M., and Curry, G. H.: Traumatic Rupture of the Spleen. Am. J. Surg. 101:357, 1961

NECK INJURY AND REAR-END COLLISION

concluded from page 254

considerable length of time, but which does not seem to cause serious organic change in the patient.

References

[1]Gotten, N.: Survey of 100 Cases of Whiplash Injury After Settlement of Litigation. J.A.M.A. 162:865-867, October 27, 1956

[2]Nagle, D.: Whiplash Injuries of the Cervical Spine. Radiology 69:823, 1957

[3]Zatzkin, H. R., and Kveton, F. W.: Evaluation of Cervical Spine in Whiplash Injury. Radiology 75:577, 1960

DOCTORS' OFFICE-SUITE FOR RENT

Medical Building

154 Waterman St., corner Cooke St.
Providence

Air Conditioning, Heating and Parking

IMMEDIATE OCCUPANCY

HOWARD REALTY COMPANY
10 Dorrance Street GA 1-5336

Masters in Medicine

DOCTOR ISAAC GERBER, 1885–1952*

The Author. *Seebert J. Goldowsky, M.D., Editor-in-Chief, the* RHODE ISLAND MEDICAL JOURNAL.

IN THE ANNUAL REPORT of Rhode Island Hospital for 1916 appeared the following interesting notation:

> "In October 1916, since the end of the fiscal year a new department was created to be known as the Department of the X-ray. Dr. Isaac Gerber has been appointed as director of this department. . . . An X-ray Department, as separate from the Pathological Department, was established in consequence of the increasing importance of the X-ray in diagnosis and in therapeutics, and also because of the high degree of specialization required to get the full benefit of this agent. The development of X-ray methods has been so rapid that the best equipment of ten years ago is entirely antiquated today. A new and up-to-date equipment will be installed."

Dr. Isaac Gerber, son of Jacob and Ida Gerber, was born in Boston, Massachusetts on May 11, 1885. After attending the elementary schools and English High School in that city, he studied at Harvard College from which he was graduated in 1907. He received his medical degree *cum laude* at Harvard University Medical School in 1910. After interning at the Boston City Hospital for a year, he did postgraduate work at the University of Thuebingen, at Stuttgart and later at Berlin and Vienna. Dr. Gerber settled in Providence in 1914 and was licensed to practice here the same year. He was the first practitioner in Rhode Island to limit his practice to roentgenology.

He conducted the affairs of the X-ray Department until 1920 when he was elevated to the position of Consultant in the Department of the X-ray. The annual report for that year contained the following statement:

> "A reorganization of the X-ray Department and the installation of a new apparatus has been made necessary by the continued development of the applications of the X-Ray both to medicine and surgery. Originally the X-Ray work was under the direction of the pathologist and was regarded as a natural adjunct to the laboratory. It subsequently developed into a science by itself quite distinct from pathology both in purpose and technique. In 1916 the hospital was fortunate in securing the services of Dr. Isaac Gerber, who has rendered most valuable service in selecting and installing new apparatus, in directing the work of the department, and in personally diagnosing cases sent in from other departments of the hospital. Of late, however, the demands upon the department have so changed in character and increased in amount that they have become greater than a visiting man can cope with, and indeed require practically the full time of a resident medical man specially trained as a Roentgenologist. Dr. James F. Boyd has been appointed to this position. . . . It would be very desirable to have a sufficient supply of radium in our institution to give proper treatment to the various forms of malignancy, especially in conjunction with X-Ray therapy. . . . That some cases were so treated is due to the kindness of the men in the Memorial Hospital in New York, the Huntington Hospital in Boston, and of Dr. Gerber of our own staff."

In the latter connection it is significant that he brought the first radium to Rhode Island for clinical use on patients.

Dr. Gerber was the first Jewish physician on the staff of Rhode Island Hospital. He developed a large private practice and was highly respected by his colleagues for his keen diagnostic acumen and his sound judgment as a consultant. His numerous contributions to the medical literature had earned for him an international reputation. He was best known locally for his work in connection with the treatment by X-ray of acute septic infections.

Afflicted in his early forties by a spinal cord disease which resulted in a progressive paralysis of his legs, he was forced at first to use a cane, then crutches, and finally a wheelchair. From this point on "Isaac Gerber's struggle against infirmity [so stated a colleague][1] was on an epic scale. With the devoted support of his wife, Rose Albert Gerber, [whom he married on November 30, 1911] a scholar in her own right and a woman of charm and

*Reprinted from *Rhode Island Jewish Historical Notes: 2*:166, 1957.

courage, he continued all his activities. For many years the short, sturdy man in the wheelchair remained a familiar sight at conferences and at nearly all regional meetings. To watch him at work, upright on his helpless legs, holding on to the fluoroscope with one hand and competently operating a spot film device with the other was an experience not easily forgotten."

The severe blow he suffered in 1943 upon the untimely death of his son at the age of twenty-five did not result immediately in any curtailment of his activities. Not only his indomitable courage, but his keen mind, pithy comments and intellectual stimulation were a constant source of inspiration to those who knew and worked with him. After an X-ray conference characterized by an unusual lack of difference of opinion, he exclaimed, "There is altogether too much agreement in this office today!"[4]

Besides being a consultant on the staff of every hospital in Rhode Island, he was a member of the Providence Medical Association, the Rhode Island Medical Society (of which he was vice-president in 1947-48) and the American Medical Association. He was a diplomate of the American Board of Radiology and a Fellow of the American College of Physicians (a unique honor for a radiologist) and of the American College of Radiology. A past president (1932-33) of the New England Roentgen Ray Society, he was a member of the American Roentgen Ray Society, the American Radium Society and the Radiological Society of North America. Swedish and British Radiological Societies honored him with nonresident membership.

Dr. Gerber retired from office practice in 1944, but his interest in his vocation did not flag. He renewed his active affiliation with Rhode Island Hospital, where his services were welcomed during the manpower shortage of the World War. Traveling daily to the hospital, he spent his mornings, sitting in a wheelchair, reading X-ray films and giving freely of his wise counsel. He carried on with these duties until 1948, when he finally withdrew from active practice. Following his retirement he continued to appear at medical meetings and conferences and was often called upon to contribute from his great experience and prodigious reading. His innate modesty rarely permitted him to make a display of his comprehensive grasp of medicine or his encyclopedic knowledge of radiology, but these were known to all.

In 1948 for the purpose of recognizing their distinguished colleague, the members of the Miriam Hospital Staff Association established an annual lectureship in his honor, to be called the Dr. Isaac Gerber Oration. The speaker would be an outstanding member of the medical profession. It is said that Dr. Gerber was the only Rhode Island physician, and one of the few in the United States, to be recognized during his lifetime by the establishment under his name of a permanent lectureship dedicated to the propagation of medical science. At first he attempted to dissuade his colleagues from embarrassing him with this unusual accolade. He relented eventually, however, and remarked: "If you want to give me the flowers while I'm still alive, they won't smell any less sweet."



ISAAC GERBER, M.D.

On the occasion of the first lecture, at which he was present, he remarked: "It felt like reading your own obituary, assuming anybody could really know what that would feel like."[7] It was held on March 10, 1948 in the library of the Rhode Island Medical Society on Francis Street, and was delivered by Dr. Merrill Sosman of Boston. The proceedings incident to this exercise have been recorded in the *Rhode Island Medical Journal* for May 1948. The eloquence and charm of Dr. Sosman's preliminary remarks and of the accompanying editorial comment merit their repetition here:

> "On March 10, 1948 the Miriam Hospital staff inaugurated an annual oration to be known as the Dr. Isaac Gerber Oration. We who have known Doctor Gerber these many years might comment at length on his accomplishments, but it is doubtful that we could pay a more eloquent tribute that than of Dr. Merrill C. Sosman, director of the department of radiology at the Peter Bent Brigham Hospital, Boston, which we quote be-

continued on next page

low. To this tribute we add the sincere appreciation of the Rhode Island Medical Society to the staff of Miriam Hospital for its thoughtful action in honoring a Fellow of our Society for whom we all have the greatest admiration.

The Editors"

The following is Dr. Sosman's tribute:

"It is a pleasure and a privilege to be with you tonight, and a great honor to be invited to give the first Isaac Gerber lecture. We, in Boston, have known Dr. Gerber for many years and have admired him not only for his ability and his learning, but also for his indomitable courage. He rarely misses any of the important medical meetings in Boston, even during the height of our beautiful winter season, and it is always a stimulus to see him in the audience. His desire to learn, his thirst to acquire knowledge have characterized him ever since I have known him.

"Dr. Gerber is essentially a Bostonian, transplanted to the salubrious soil and climate of suburban Providence. He was born in Boston, educated in the Boston English High School, Harvard College and Harvard Medical School, where my researches reveal that he was graduated cum laude. He was an intern at the Boston City Hospital and it was there that his future career was determined, but without his realizing it until several years later. At the City Hospital he came into contact with, and fell under the spell of, Francis H. Williams who first interested him in the strange new x-rays, particularly their use in examining the heart and lungs of the patients on his wards. Those of you who knew Dr. Williams will remember what an enthusiast he was. — quiet, scholarly and thorough, but a missionary in thought and deed in those benighted days when physicians thought they could diagnose with the stethoscope!

"Having been inoculated with the virus of Roentgenology, Dr. Gerber exposed himself to still further infection by studying with Levy-Dorn in Berlin, Haudek and Holzknecht in Vienna, and was a friend and co-worker with Arthur Schueller at the Allgemeine Krankenhaus where his interest in cranial roentgenology was aroused. That was in 1912, the year that Christian and Cushing and their associates toured Europe with the purpose of obtaining ideas and perhaps men for the new Peter Bent Brigham Hospital, about to be opened in Boston the following year. But for a missed appointment with Cushing, Dr. Gerber might have been the new Roentgenologist at my hospital, and then I would not have been here on this happy occasion.

"It is unnecessary to remind you, I am sure, that Dr. Gerber gently metastasized to Providence in 1914 (the first physician in this state to limit his practice to Roentgenology), and of how much he has done for medicine and Roentgenology in the 34 years since he has been one of you. For several years he maintained a base of operation in Boston, but finally recognizing the superior virtues of Providence severed official connection with his native town and has since concentrated his effort in your city. He was active in establishing the department of radiation therapy at the Boston City Hospital in 1924, and a similar one at Pondville Hospital in 1927. He is or has been on the staffs of most of the hospitals in Rhode Island, belongs to all of our national radiological societies, is a life member of the British Institute of Radiology and is currently, I understand, a Vice-President of the Rhode Island Medical Society. His contributions to the medical literature have been numerous and varied, and I know of no one in our X-ray Societies who has as thorough a knowledge of radiological literature as Dr. Gerber.

"Dr. Gerber has always been an Index Medicus and a peripatetic library for our radiological meetings and clinics not only in New England but all over the country. . . ."

Dr. Gerber's graceful and modest response follows:

"There is very little that one can say in response to such eulogies as have been heaped on me tonight. You all realize of course that this is an extremely unusual occasion, at least from my point of view.

"Named lectures generally have been inaugurated in honor of individuals who have already passed on. In the present instance my colleagues and friends of the Miriam Hospital staff have chosen figuratively to send me flowers while I am still around and able to enjoy their fragrance and beauty. It is certainly not for me to decry their choice.

"The idea of the annual lectureship in itself is indeed a most admirable one. It is a fitting way of having the hospital, now well along in its third decade of service, show its appreciation of being a real part of the medical community of Rhode Island.

"As for myself, I can only state that I am indeed extremely appreciative of the high honor that has been given to me by attaching my name to this projected series of lectures. I am also greatly touched personally by this overwhelming indication of friendliness and esteem on the part of my colleagues in the Miriam Hospital.

"I know that you have not gathered here tonight to listen to me. I do not feel that I should encroach further on the speaker's time, and wish

once more to express my deepest thanks for this tremendous honor."

Until his death Dr. Gerber attended the lectures. As of this writing nine orations have been delivered by a distinguished roster of nationally known physicians, the last on October 17, 1956. In recent years it has been the custom to hold this exercise on the third Wednesday of October in the auditorium of Miriam Hospital.

Dr. Gerber died on February 17, 1952 of coronary thrombosis following a long and painful siege of sciatic pain associated with his illness. His progressive paralysis, which had continually baffled neurologists and which had been ascribed to radiation injury of his spinal cord, was found after his death to have been caused by a benign cord tumor. It is an irony of fate that this brilliant diagnostician succumbed to an ailment which could have been cured had the correct diagnosis been made.

Long a member of The Congregation of the Sons of Israel and David (Temple Beth-El), he is buried in the Reservoir Avenue Cemetery. He is survived by Mrs. Gerber and a married daughter. Obituaries have appeared in the *Journal of the American Medical Association*, the *Rhode Island Medical Journal*, the *Annals of Internal Medicine*, *Radiology*, the *American Journal of Roentgenology* and the *British Journal of Radiology*.[1,5,6,2,4,3]

FOOTNOTE TO HISTORY

HAROLD W. WILLIAMS, M.D.

Upon hearing the recent Isaac A. Gerber oration, I was reminded of a distorted imprint relative to the central nervous system disease from which Doctor Gerber suffered. At the time of the gross dissection of the central nervous system, it was observed that there was an arc-like enlargement of the spinal cord between thoracic levels 6 and 8. It was interpreted that this might be a type of benign tumor. This suggested the possibility of a missed diagnosis which tends to make a deep impression on professional minds. However, microscopic study revealed otherwise, but seemingly, this did not correct the erroneous first impression.

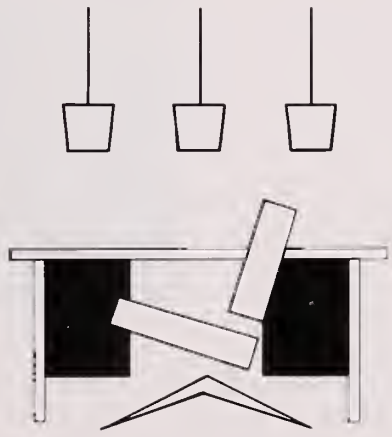
The microscopic study revealed that this arc-like enlargement was a congenital anomaly known as reduplication of the spinal cord. This reduplication of the spinal cord had no significance with respect to the disorder that handicapped Doctor Gerber for so many years. The pathological basis for his disorder was multiple sclerosis. Typical plaques of this disorder were found in the cerebrum, the brain stem, and the spinal cord. The lumbar and sacral cords were free from this disorder. The disease was not progressive at the time of his death.

Arterio- and arteriolar sclerosis had produced changes in the central nervous system. There was a relatively old encephalomalacia of the right cerebellar hemisphere. The ravages of vascular disease had resulted in an old and recent myocardial infarction which was the most immediate cause of death.

It is trusted that the above will make for greater accuracy in the facts available to future generations with respect to this man of history.

concluded on page 265

Butterfield's
DRUG STORE
CHARLES BUTTERFIELD, Ph. G.
Corner Chalkstone & Academy Aves.
ELMHURST 1-1957
Pharmacy License #193

Attractive & Functional Offices
by BENÉ & CO., INC.

Designers & Suppliers of Offices
150 Dorrance Street • Providence 3, R. I. • GAspee 1-5228

Editorials

DON'T YOU BELIEVE IT!

ONE OF THE LEADING PROPONENTS of the King-Anderson bill to provide medical care only for beneficiaries of the Social Security System, by means of a tax on every worker of America, is the AFL-CIO. In a March 28 news release by the director of the department of legislation of that organization the statement is made that

"We in the AFL-CIO are convinced that President Kennedy's program, as embodied in the King-Anderson Bill, H.R. 4222, is a sensible and, indeed, a conservative approach to the problem."

At the White House Conference on Aging held early in 1961 in Washington the AFL-CIO presented its views on this issue by means of a large exhibit display (see photo below) in which this "sensible" and "conservative approach" to the problem is set forth in this most inconsistent manner:

Today . . . Can They Afford to be 65?

Three out of five elderly citizens live on less than $20.00 per week—three out of five have no health insurance protection.

One-half cannot afford the cost of proper housing, nutrition, or adequate medical care. . . .

The health needs of older people are three times greater than those in their working years.

THEY DESERVE MORE . . . . . NOW!

The Answer . . .

Better and Broader Social Security

For twenty-five years Social Security has proven our best defense against economic insecurity in old age. The same system can provide sound health protection in old age.

The Social Security System is the only practical method of providing health protection for the greatest number of older people.

Improved benefits and broader coverage can meet the crushing burdens of medical care.

MEDICAL CARE THROUGH SOCIAL SECURITY . . . EARNED BY OUR OLDER GENERATION . . . A MATTER OF RIGHT!



* * *

This then is organized labor's clear pronouncement to the American people: The Social Security System you were obliged to pay into since 1937, and which promised that when you were ready to retire in 1962, or later, it would give you economic security in your old age, now cannot give you

One-half the cost of proper housing

One-half the cost of proper nutrition

Adequate medical care.

In spite of this situation, says the AFL-CIO, the only answer is better and broader social security!

For twenty-five years, says the AFL-CIO, social security has proven our best defense against economic insecurity in old age. Presumably, it forgot

to read its previous statement about housing, food and health care when it made this generalization.

Consider also the bold pronouncement—MEDICAL CARE THROUGH SOCIAL SECURITY—EARNED BY OUR OLDER GENERATION—A MATTER OF RIGHT!

Just when did the estimated fifteen million citizens over the age of 65 earn the right to collect medical care benefits under the present Social Security System which has never taxed them—nor anyone else—for such care?

We respect the right of every person, or organization, to express its opinions on any and all legislation, state or federal. But we do take exception to propaganda prepared to confuse the issue and mislead the average citizen, and we strongly criticize the undocumented generalization technique which attempts to state as fact what is actually false. For example, in his release to citizens "with an established and continuing interest in public affairs," the director of legislation of the AFL-CIO, former Congressman Andrew J. Biemiller, states—

> "However, those of us who favor the President's program are keenly aware that the unyielding opposition of the American Medical Association, exerted through the wealthiest lobby in Washington, set forth in costly newspaper advertising which the proponents cannot match, and reinforced by the tightly knit organization of affiliated medical societies throughout the nation, represents a formidable obstacle."

What are the facts?

During 1961 labor unions spent $1,010,365.00 for lobby expenses. The A.M.A. expense was only $163,404.61.

The total for all AFL-CIO unions alone came to $730,101.00, and of this amount the AFL-CIO parent group spent $133,919.01. AFL-CIO affiliates spending large sums were: United Federation of Postal Clerks, $73,867.83; and the International Association of Machinists, District Lodge No. 44, $71,736.62.

The Labor figure does not include the expenses of the Railway Labor Executives Association which is made up of the executives of 21 AFL-CIO unions and two independent unions. It also does not include the expenses of registered lobbyists of 17 unions which includes such unions as the United Automobile, Aircraft and Agricultural Implement Workers (AFL-CIO), United Steelworkers of America (AFL-CIO), United Mine Workers of America (Independent) and the Amalgamated Meat Cutters and Butchers Workmen of North America (AFL-CIO).

Did you mean, Mr. Biemiller, that the American Medical Association's opposition is being exerted through the AFL-CIO which is the wealthiest lobby in Washington?

GOVERNOR NOTTE AND IRRESPONSIBILITY

ONLY A FEW HOURS before the last possible deadline Governor John A. Notte vetoed a bill, passed by the 1962 General Assembly in its closing hours, which would have broadened Rhode Island Medical Society Physicians Service coverage to include chiropractors. In an act of duplicity quite parallel to that of a year ago, when podiatrists, who are not physicians in any sense, were blanketed into the physicians' plan during the closing minutes of the Assembly session, the chiropractors' bill was passed in the middle of the night when ordinary people were properly in bed.

Under different circumstances we would applaud the Governor's action as forthright and in the public interest. His accompanying remarks, however, we find reprehensible and demonstrating an incredible lack of comprehension of the public welfare.

"I would," he stated, "like to point out that the practice of chiropractic has been of great benefit to the people of Rhode Island." He then added, gratuitously: "Some reasons advanced in opposition to this measure, particularly by members of the medical profession, appear to be based more on considerations of their own self-interest, rather than on the merits of the particular proposal." In a weak gesture to respectability, he concluded: "I want it clearly understood that my present action is based only on my wish to see more thorough consideration by the Study Committee (set up by the General Assembly to study the Blue Plans)."

The irrational and unscientific cult of chiropractic is defined as follows: "A system of therapeutics based upon the *claim* (italics ours) that disease is caused by abnormal function of the nerve system. It attempts to restore normal function of the nerve system by manipulation and treatment of the structures of the human body, especially those of the spinal column." This whole cult is based upon the peculiar hunches of a rather silly quack named Daniel David Palmer who died in 1913.

The American Medical Association, a bulwark

continued on next page

of protection for the public against quackery, describes chiropractic as a cult practice "not supported by scientific or demonstrated knowledge," but having a single basis "on which all diseases are treated." In its *Principles of Medical Ethics* it states: "The (Judicial) Council has emphasized the importance of maintaining the dignity of medicine and of upholding the soundness of the teachings of scientific medicine as opposed to the fallacies of sectarianism. Either the theories and practices of scientific medicine are right and those of cultists are wrong, or the theories and practices of the cultists are right and those of scientific medicine are wrong. The physician who maintains professional relations with cult practitioners would seem to exhibit a lack of faith in the correctness and efficacy of scientific medicine and to admit that there is merit in the methods of the cult practitioners. The profession of medicine is the custodian of the accumulated knowledge in medicine which should be used for the benefits of mankind."

With these ideals in mind, it is clear that the inclusion of chiropractors in the Rhode Island Medical Society Physicians Service coverage, whether in 1962 or in any other year, would categorically necessitate abandonment of the plan by the physicians of this state.

While these columns traditionally maintain a nonpolitical posture, we are obliged to conclude that the doctors of Rhode Island, in view of their professional obligations, have compelling reasons to seek new leadership in the State House.

AFFECTS AND EFFECTS

PUBLISHED ELSEWHERE in this issue is the 14th Annual Gerber Oration delivered by Doctor George L. Engel, professor of psychiatry, and also associate professor of medicine at the University of Rochester. The title of this thoughtful essay is *The Nature of Disease and the Care of the Patient: The Challenge of Humanism and Science in Medicine*. Physicians have for millenia pondered over the relationship between the emotions and disease. The ancient writers placed the emotions in certain organs, giving rise to such expressions as venting of spleen, phrenetic, hysterical, and heartfelt. Raynaud had noted a mild hysterical tendency in some of the young women exhibiting the disorder which he described. Cannon and Pavlov have shown in classical experiments the relationship between the central nervous system and bodily function. The story of Beaumont and Alexis St. Martin is not without bearing. Many observers have commented upon the deleterious effects of fear and poor morale. Any experienced surgeon is reluctant to operate upon patients terrified of death or totally discouraged.

Doctor Harry K. Beecher, professor of anaesthesiology at the Massachusetts General Hospital, recently touched upon this broad problem in his Bengué Lecture before the Royal Institute of Public Health and Hygiene in London (J.A.M.A., February 10, 1962). In this lecture, titled *Nonspecific Forces Surrounding Disease and the Treatment of Disease*, he stated: "Granted that any sensible view of disease must embrace many factors, microbial, mental, environmental, and so on, a number of unspecific factors have not been given their due . . . the outlines are emerging of what a thorough study must include; new considerations of the patient, the physician, the interrelationships, the physical setting — whether home or hospital — and the social environment."

The objective observations in Doctor Engel's study are interesting and pertinent. As an accomplished internist, as well as psychiatrist, he is well qualified to give authority to his views. This scientific evaluation of grief as a disease should, we feel, be of great interest, and we recommend it to our readers for careful appraisal.

CHIROPODY (PODIATRY)

SECTION 13 of Chapter 112, as printed in the Tercentenary Edition (1932) of the *General Laws* of Massachusetts, defines chiropody as follows:

> "Chiropody" as used in this chapter shall mean the *external treatment* of structures of the human foot by *medical, mechanical* or *surgical* means without the use of other than local anaesthetics. [Italics added.]

A review of podiatric legislation in Massachusetts since that date reveals the familiar pattern of a fringe medical group's struggle for broader horizons and recognition. In 1945 the law relating to possession and use of hypodermic needles and syringes was amended to allow a chiropodist to possess and use them if he "received from the board of registration in chiropody a certificate stating that upon examination by said board he has been determined to be competent to use hypodermic needles. . . ." Ten years later the General Court enacted Chapter 684 (Acts of 1955) permitting ex-

amination of feet of schoolchildren by chiropodists.

In 1956 the definition of chiropody was changed by Chapter 344 to read:

> "Chiropody" (podiatry) as used in this chapter shall mean the diagnosis and the treatment of the structure of the human foot by *medical, mechanical, surgical, manipulative* and *electrical* means *without the use of other than local anaesthetic, and excepting treatment of systemic conditions*, and excluding amputations of the foot or toes. [Italics added.]

In the same year the legislature authorized chiropody treatment for recipients of old-age assistance "after consultation, confirmed in writing by the attending physician." This restriction was removed in 1957. And, in 1959, Chapter 130 was enacted, providing that any medical-service corporation "*may* enter into contracts with its subscribers and with participating physicians, dentists *and chiropodists* (podiatrists) licensed under the laws of the Commonwealth for such medical and surgical services as may be rendered by them to the subscribers and may pay for such services." This year the chiropodists are petitioning the General Court to make it mandatory that Blue Shield pay chiropodists for compensable services rendered to Blue Shield subscribers.

The chiropodists' struggle for recognition and prestige and attempts to broaden their base of practice (in Massachusetts chiropodists so inclined may legally perform, for example, a sequestrectomy for osteomyelitis or bone abscess) is not confined to Massachusetts. Nationally, the chiropodists have, for a small organization, been exceptionally effective in legislative and judicial chambers. In Delaware chiropody includes the diagnosis and the medical, surgical, mechanical, manipulative and electrical treatment of *all the ailments of the human foot and leg*, except for amputation of the foot or leg or the administration of an anesthetic other than local. Vermont allows chiropodists to treat minor ailments of the foot *or hand* medically, mechanically or surgically. In Ohio, too, chiropodists may treat ailments of the hand and foot, nonsystemic in character, and the muscles and tendons of the lower leg governing the functions of the foot.

Several Blue Shield plans throughout the country now pay for services of chiropodists.

The Massachusetts Medical Society opposes mandatory inclusion of chiropodists in Blue Shield particularly because Blue Shield subscribers are denied nothing by failure to include podiatry. Such services are available to them from participating physicians.

A basic question at issue is just how far Blue Shield should extend itself. Should it become a broad umbrella encompassing all services of allied medical groups at the risk of its financial integrity, or should it remain as originally planned—a prepaid insurance program to cover physicians' fees? It is interesting that Massachusetts dentists and optometrists have, through their respective organizations, petitioned the General Court for legislation that would allow these two groups to establish separate prepaid plans for their members' services.

The chiropodists would well follow suit. Chances are, however, that if they are not successful in their legislative bid for mandatory inclusion as were the chiropodists in New York, they will go to the courts, like their successful confreres in Washington, D. C.

The medical profession has no quarrel with podiatrists, and the relations between the two groups in Massachusetts have been mutually respectful, cordial and co-operative. In its efforts, however, to keep its own house in order and to maintain the highest possible standards of medical care and practice in the interest of the public it is dedicated to serve, the medical profession is understandably annoyed at the constant clamoring for admission through its battered back door.

. . . Reprinted from the NEW ENGLAND JOURNAL OF MEDICINE, March 1, 1962 issue.

DOCTOR ISAAC GERBER, 1885-1952

concluded from page 261

REFERENCES

[1]J.A.M.A. 149:76, 1952
[2]Radiology 58:586, 1952
[3]Brit. J. Radiol. 25:34, 1952
[4]Am. J. Roentgenol. 67:1003, 1952
[5]Rhode Island M. J. 36:54, 1952
[6]Ann. Int. Med. 37:645, 1952
[7]The Evening Bulletin, Providence, R.I., April 14, 1950

MANUSCRIPTS

Manuscripts for publication and correspondence relating to them should be sent to:

Editor, RHODE ISLAND MEDICAL JOURNAL
106 Francis Street
Providence 3, Rhode Island

Manuscripts should be typewritten on one side of the paper only, double-spaced, and with liberal margins. References should be placed at the end of the article and should conform to the style of QUARTERLY CUMULATIVE INDEX MEDICUS, giving author, title, journal, volume, page, month and year (*e.g.*, Doe, J.: Calcium Therapy, Rhode Island M. J. 61:22 June, 1961). References to books, monographs and pamphlets should indicate the author, the title, the name and city of the publisher, the year of publication, edition, and page number of the reference.

Patronize Journal Advertisers

BRIEF SUMMARY OF THE PRESENT STATUS OF SELECTIVE SERVICE AS IT RELATES TO PHYSICIANS

DURING THE CALENDAR YEAR 1961 three Selective Service calls for physicians were issued. This was the first time such calls have been necessary for several years. However, during the past year there was a decrease in volunteers and an increase in the numbers required by the Armed Forces as a result of the mobilization program. This increase in requirement was obtained by:

1. Discontinuing the acceptance of resignation of regular officers.

2. Denying release of those reserve officers who had voluntarily extended their active duty for an indefinite time.

3. Selective Service call up of 1,025 physicians.

4. Call to active duty of National Guard and Reserve Units with medical officers attached.

Because physicians, dentists and other medical specialists, generally speaking, are liable for military service until age 35, and because they may be called as a special group, they were given the following considerations:

1. Those in a reserve status who were called as filler personnel on or after September 1, 1961 and who had completed at least 21 months previous active duty were given the opportunity to be released shortly after the activation of the unit.

2. Those reserve officers on active duty serving only their required two years were released at the end of their tour.

The physicians called up by Selective Service were those in the youngest age group who had completed their internship. This group, therefore, included almost exclusively first-year residents and physicians just beginning private practice. Since the call was based on age it was not evenly distributed and some hospital training programs suffered a depletion of their first year residents while others were untouched.

Because of the possibility of future Selective Service calls for physicians in time of a crisis it would be well to consider the measures which are available to ameliorate the effect on hospital staffs and civilian communities. These are:

1. *Appeal of classification of 1-A (available for military service) to the Appeal Board.*

Shortly after completion of internship, physicians are normally classified by Selective Service in Class 1-A. An appeal may be made within ten days after receipt of this classification by filing with the local board a written notice of appeal. If the physician is located in an area other than that covered by his local board he may request that his appeal be submitted to the appeal board having jurisdiction over the area where he resides.

2. *Request for determination of essentiality.*

A physician who receives a Selective Service induction notice may, if he is essential to his community or hospital and if his essentiality can be documented, request a determination of such essentiality from his local or State Selective Service Advisory Committee. Copies should be sent to the advisory committee where he is located if this is different from the committee governing the area of the board where the physician is registered. Such a request may also be directed to the National Advisory Committee to the Selective Service System, Washington, D.C.

3. *Delay in reporting to active duty.*

Physicians who have received induction notices and have been commissioned may apply to the Armed Service in which they are commissioned for a delay in reporting to their duty station. Such request must be supported by evidence of essentiality or severe personal hardship.

For those physicians who do not wish to subject themselves to the uncertainties of the draft, the Armed Forces Physicians' Appointment and Residency Consideration Program (Berry Plan) provides for a reserve commission with entry on active duty at one of the following times:

1. Immediately upon completion of internship.

2. As late as one year following internship.

3. Upon completion of residency training in specialties required by the Armed Forces.

Application may be made for participation in this program early during the intern year. Acceptance into any of the three categories is dependent upon the projected needs of the Armed Services.

* * *

(Prepared at the request of the A.M.A. Council on National Security by EUGENE V. JOBE, M.D., Medical Liaison Representative, A.M.A. Washington Office, and JAMES E. FITZGERALD, M.D., Member, A.M.A. Council on National Security, April 9, 1962)

INDICATION: *Accidental trauma*



INDICATED:
Chymoral®

cuts healing time in accidental trauma

Whether the patient presents the simple edema and inflammation of a sprained ankle or the severe lacerations and bruising from a violent accident, immediate adjunctive use of Chymoral speeds resolution of traumatic manifestations. Chymoral modifies the inflammatory reaction to trauma, dissipates edema and blood extravasates, improves regional circulation, and thus aids the body's natural reparative activities. In other general practice areas, too, Chymoral cuts healing time. Excellent results have been achieved in acute sinusitis, bronchitis, bronchial asthma, emphysema, chronic pelvic inflammatory disease, and acute thrombophlebitis.[1-5]

Controls inflammation, curtails swelling, curbs pain

1. Beck, C., *et al.*: Clin. Med. 7:519, 1960. 2. Teitel, L. H., *et al.*: Indust. Med. *29*:150, 1960. 3. Billow, B. W., *et al.*: Southwestern Med. *41*:286, 1960. 4. Clinical Reports to the Medical Department, Armour Pharmaceutical Company, 1960. 5. Taub, S. J.: Clin. Med. 7: 2575, 1960.

ARMOUR PHARMACEUTICAL COMPANY
KANKAKEE, ILLINOIS *Originators of Listica®*

CHYMORAL

Chymoral is an ORAL anti-inflammatory enzyme tablet specifically formulated for intestinal absorption. Each tablet provides enzymatic activity, equivalent to 50,000 Armour Units, supplied by a purified concentrate which has specific trypsin and chymotrypsin activity in a ratio of approximately six to one. ACTION: Reduces inflammation of all types; reduces and prevents edema except that of cardiac or renal origin; hastens absorption of blood and lymph extravasates; helps to liquefy thick tenacious mucous secretions; improves regional circulation; promotes healing; reduces pain. INDICATIONS: Chymoral is indicated in respiratory conditions such as asthma, bronchitis, rhinitis, sinusitis; in accidental trauma to speed absorption of hematoma, bruises, and contusions; in inflammatory dermatoses to ameliorate acute inflammation in conjunction with standard therapies; in gynecologic conditions such as pelvic inflammatory disease and mastitis; in obstetrics as episiotomies and breast engorgement; in surgical procedures as biopsies, hernia repairs, hemorrhoidectomies, mammectomies, phlebitis and thrombophlebitis; in genitourinary disorders as epididymitis, orchitis and prostatitis; in dental and oral surgery as fractures of the mandible or maxilla, difficult or multiple extractions, and alveolectomies. CONTRAINDICATIONS: None known. INCOMPATIBILITIES: None known. Antibiotics as well as generally accepted measures may be coadministered. SIDE EFFECTS: Mild gastric upsets, rarely encountered. DOSAGE: Recommended initial dose is two tablets q.i.d.; one tablet q.i.d. for maintenance. SUPPLIED: Bottles of 48 and 250 tablets.

CHYMORAL *ORAL systemic anti-inflammatory enzyme tablet*

EXIT OF DOCTORS TALLIED IN BRITAIN

Reprinted from the *Christian Science Monitor,* March 16, 1962

ARE CONDITIONS in Britain's National Health Service driving young doctors overseas?

This is the question raised by figures published here showing that one in three of those who graduate from medical schools in Great Britain and Ireland practices abroad.

A mass migration of young British doctors is taking place "on a scale hitherto unknown," according to Dr. John Seale, consultant in medical economies and health services.

Dr. Seale has collected and analyzed official information about the licensing and registration of British doctors throughout the Commonwealth, in the United States, and in international organizations such as the World Health Organization.

Oversea Practices

The report on his investigation published in the current issue of the British Medical Journal shows that an average of 700 doctors a year leave the British Isles. This is five times the rate of the 1930's.

During the 5 years 1956-60, 3,530 doctors decided to practice overseas — 1,071 in Canada, 1,060 in Australia, 748 in the United States, 202 in South Africa, 184 in New Zealand, 145 in Southern Rhodesia, and 119 in Northern Rhodesia.

Britain also has supplied doctors to assist the underdeveloped countries in the 1950's at twice the rate prevailing in the 1930's.

"A possible explanation of the phenomenon," Dr. Seale says, "is that practice in the National Health Service is relatively unattractive to young doctors economically, professionally, and idealistically."

The inflow of doctors from India, Pakistan, and other countries in the hospitals in Britain, Dr. Seale holds, does not mean that the Service has permanent attractions for them. Most come to Britain to enhance their professional standing and then return to their own country.

"If as many British doctors have left Britain in recent years as official sources abroad indicate," Dr. Seale says, "then it may be concluded that the younger generation of the British medical profession is already severely depleted."

Observations made in hospitals throughout England confirm this conclusion because most have few British doctors working in them under the age of 40 and many have none. The Times, of London, pointed out recently that the junior staff of many hospitals is entirely from overseas.

Lack of flexibility in and difficulty in getting out of the National Health Service is held responsible for the decision of many ambitious young doctors to practice abroad. The excellent equipment and conditions in the United States have acted as a magnet to draw those keen on research.

While many people here praise the National Health Service, and especially its dental side, for the insurance it gives in cases which receive extensive treatment, there is an increasing tendency on the part of professional and other middle-class heads of households to take out private insurance policies against medical expense. Such insurance provides fees for treatment outside the national health schemes or for care in a private clinic, wherever the state-run hospitals are considered inefficient or overcrowded.

Cost Underlined

Speakers in debates in the House of Commons repeatedly have pointed out the great mistake of considering the health service a free service. The nation has to pay for it. A large portion of the national taxation goes for its upkeep. Each worker pays his contribution weekly. Those who do not use its facilities pay for those who do.

E. P. ANTHONY, INC.
Druggists
WILBUR E. JOHNSTON, Phar. D.
RAYMOND E. JOHNSTON, B.S.
178 ANGELL STREET
PROVIDENCE, R. I.
GAspee 1-2512
Pharmacy License #225



Clear the air with ALEVAIRE®

inhalation therapy

WETS, THINS, LOOSENS PULMONARY SECRETIONS

Very useful in...

... BRONCHITIS
BRONCHIAL ASTHMA
BRONCHIECTASIS
PERTUSSIS
CROUP

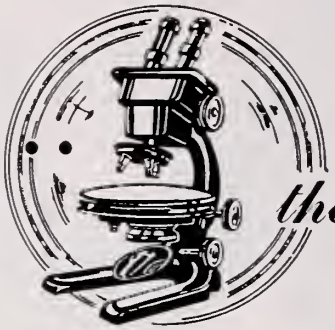


Alevaire is administered by means of a nebulizer operated with an air compressor or oxygen.

Supplied in bottles of 60 cc. for intermittent and 500 cc. for continuous nebulization.

Winthrop LABORATORIES
NEW YORK 18, N. Y.

Alevaire, trademark reg U.S. Pat. Off.

THROUGH . . .  *the Microscope*

A.M.A. Department of Medicine and Religion Organized

"How to provide better health care for 'the whole man.' That is the chief concern of our new department." This is the Reverend Doctor Paul B. McCleave's nutshell definition of the American Medical Association's new Department of Medicine and Religion which he heads.

The department was opened last September with the goal of encouraging closer relationships between physicians and clergymen in patient care.

Doctor McCleave feels that the best patient care is achieved when physicians and clergymen are able to share mutual concern for the patient and when each contributes his special talents to the problem at hand.

Terminal illness, he points out, is an excellent example of an area in which the clergy can be of particular help to physicians.

The new department will foster close physician-clergy relationships through programs carried out on the local medical society level and tailored to fit local needs.

Doctor McCleave is currently working with medical society leaders and physicians in nine states where pilot programs will be launched. These states, chosen as a representative cross-section of the entire nation, are: Arizona, Georgia, Iowa, Maryland, Montana, New York, Ohio, Texas and Utah.

Safety Rules Can Cut High Poisoning Toll

On an average day in the United States, more than 2,200 accidental poisonings occur, the Health Insurance Institute said recently. This toll could be drastically reduced by the widespread adoption of a few simple safety measures, said the Institute.

The U. S. National Health Survey has estimated that 822,000 accidental poisonings occurred in the year ending June 1959, and 302,000 of these were in children under age five, stated the Institute. During 1959, some 1,660 individuals died due to accidental poisoning and 456 were under age five.

The Institute said the four classes of products most often involved in accidental poisonings are internal medicines, cleaning and polishing agents, pesticides, and petroleum distillate products.

The three factors attributable to a majority of these poisonings are: products not properly stored, products stored in something other than their original container and improper discarding of toxic products.

To focus attention on accidental poisonings, Congress designated the week of March 18-24, 1962, for the first annual observance of National Poison Prevention Week.

Poison Precautions

The Institute passed along the following list of precautions which, if conscientiously observed, could sharply reduce the number of accidental poisonings in children:

1. Store household preparations such as lye, cleaning and polishing agents, soaps, and kerosene high in cabinets out of the reach of children or in a locked cupboard.
2. Store all medicines in locked cabinets.
3. Always return products to safe storage places; never leave in open.
4. Never store in another container, particularly one used for food.
5. Discard unwanted medicines and household products by flushing down toilet.
6. Read and heed labels; use according to directions on cans.
7. Do not administer medicine in the dark or without carefully reading the label.
8. Never call medicine "candy."

Britains Socialized Hospital System Critically Analyzed

"The British hospital service is in a perilous position. It needs some leaders with fire in their bellies to tackle the problem with vigor—even if it means being unpopular."

This opinion of socialized hospital care in Great Britain comes from a former English hospital ad-

continued on page 272



Emotional control regained... a family restored... thanks to a doctor and 'Thorazine'

During the past seven years, 'Thorazine' has become the treatment of choice for moderate to severe mental and emotional disturbances because it is:

- specific enough to relieve underlying fear and apprehension
- profound enough to control hyperactivity and excitement
- flexible enough so that in severe cases dosage may be raised to two or three times the recommended starting level

Experience in over 14,000,000 Americans confirms the fact that, in most patients, the potential benefits of 'Thorazine' far outweigh its possible undesirable effects.

Of special value in mental and emotional disturbances: Tablets for initial therapy; Injection (Ampuls and Vials) for prompt control; Spansule® sustained release capsules for all-day or all-night therapy with a single oral dose.

Smith Kline & French Laboratories SK&F

Thorazine®

brand of chlorpromazine

A fundamental drug
in both office and hospital practice

For prescribing information, please see PDR or SK&F literature.

Posed by professional models.

THROUGH THE MICROSCOPE

continued from page 270

ministrator James A. Willan. In an exclusive article in HOSPITAL MANAGEMENT magazine, he charges that Britain's 13 years of government medicine has produced "low morale" and "frustration" among hospital employees and a crop of "yes men" for administrators.

According to Willan, who is now in the United States associated with a hospital consulting firm, "bureaucracy is slowly becoming the master of the English hospital system." He points out that more than 5,500 committees (with 60,000 members) have been appointed to manage the 480,000 bed system —about one committee member for every eight beds. "This," he says, "has bogged the hospital service in a mass of boards and committees with overlapping responsibilities. It has few people of ability, but an overabundance of enthusiastic amateurs whose only asset is time."

As a result, says Willan, "everything seems to be done the hard way. Paper work increases, filing cabinets bulge, and no one has time to read anything thoroughly. It is like a spinning wheel that gets nowhere."

The lag in building and new equipment procurements is also criticized by Willan. "Twentieth century medicine is having to use eighteenth and nineteenth century buildings," he says. "New building is halted because by the time plans have gone through the committees and boards, years have passed and money is unavailable to complete them."

Willan traces the root of British hospital problems to the fact that "nothing is done to stimulate original thinking. There are no incentives," he says, "no suggestion system and no place for the occasional non-conformist." He charges that management "deals with existing situations instead of planning so that the situation will not arise. Therefore, he says, "such programs as public relations, fire prevention, work safety and disaster planning are unknown."

Willan calls for leadership to restore the English hospital service to "a great tradition of human kindness and efficient care of the sick." "If this does not happen," he warns, "tomorrow's standard will be copied from today's low standards."

The complete article, titled *Government Control —How Effective Is It?* appears as a two-part series in the March and April issues of HOSPITAL MANAGEMENT, the Journal for Administrators and Department Heads, Chicago, Illinois.

Mr. Willan is on the staff of John G. Steinle and Associates, Garden City, Long Island, New York.

U. S. Hospitals Increasingly Dependent on Foreign Graduates

Hospitals in the United States are becoming increasingly dependent upon graduates of foreign medical schools to help fill their house staff positions, the Public Health Service said today.

In 1951, 2,100 graduates of medical schools outside the U. S. were serving as hospital interns and residents; by 1960, this figure had reached 9,500.

Although the number of medical school graduates each year has increased about 40 per cent since 1940, and almost all graduates take intern training, the number of internships offered increased almost 90 per cent in the twenty-year period. Even with many internships filled by foreign graduates, only 82 per cent of the positions offered were filled in 1960, according to the Service.

With the increasing trend toward specialization in medical practice there has been a greatly increased demand for residency training since World War II. However, the number of positions offered has increased much faster than the number of American-trained physicians seeking such training. In spite of the 6,900 residency positions filled by foreign graduates, only 87 per cent of all residencies offered were filled in 1960.

About eight years ago, a committee, including representation from the Federation of State Medical Boards of the U. S., the Council on Medical Education and Hospitals of the A.M.A., the Association of American Medical Colleges, and the American Hospital Association, was formed to develop a program for the evaluation of foreign-trained physicians. As a result of the study of this committee, the Educational Council for Foreign Medical Graduates (ECFMG) was set up in 1957. Since July 1, 1960, certification by the ECFMG has been a prerequisite to appointment to an intern or resident position in a hospital in the United States.

Red Chinese Medical Great Leap Backward

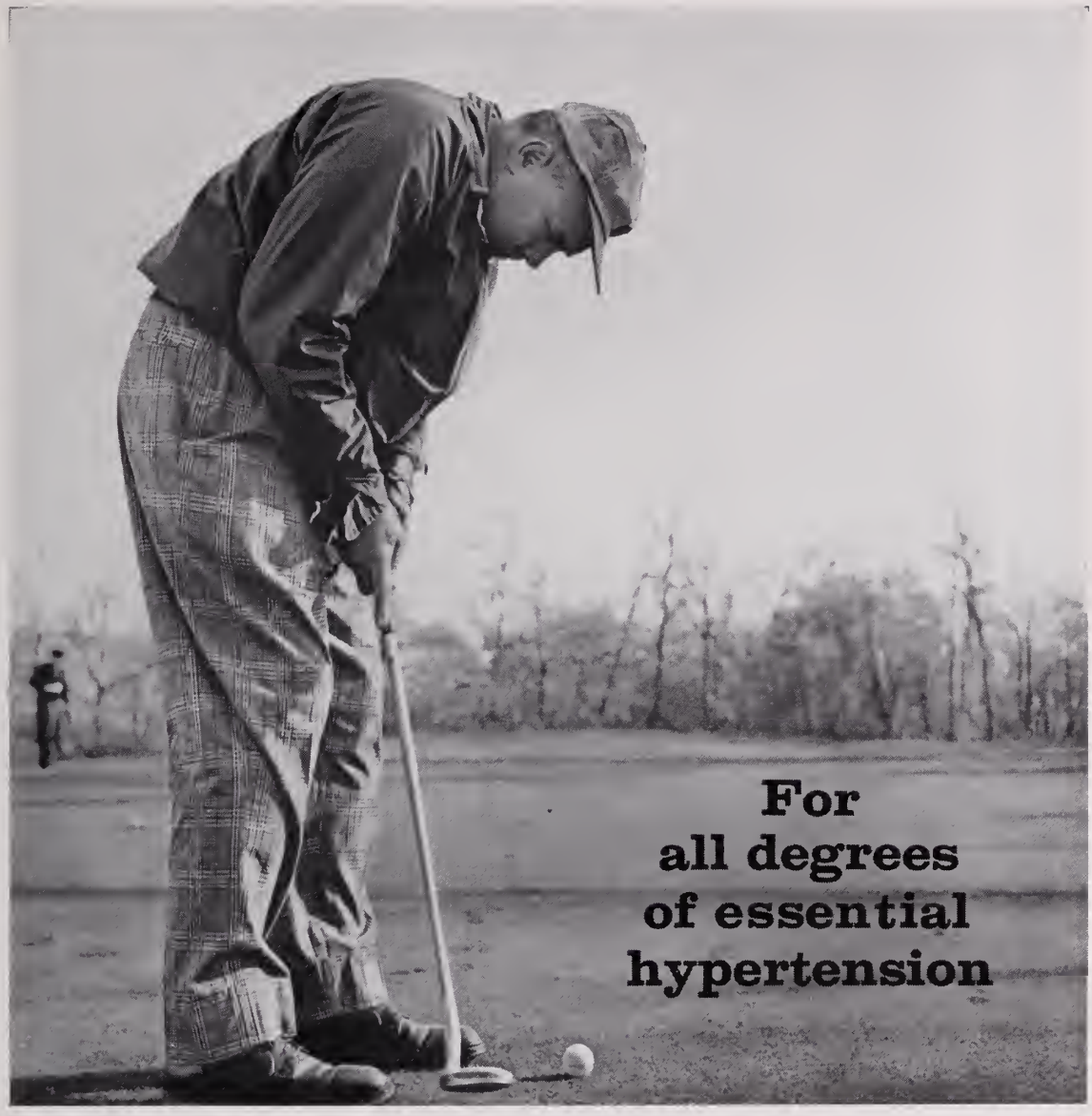
The health of Red China's 600 million people is in the hands of "perhaps the most undertrained, medievally oriented, and politically infected medical profession in the world," according to Arturo F. Gonzalez, Jr., creative director of The Asia Magazine, Hong Kong.

Writing in the April TODAY'S HEALTH, published by the American Medical Association, Gonzalez said in 1958 the Red Chinese took "a giant step backward—a step they are still taking."

China's Western-trained physicians, the cream of the country's medical profession, in 1958 were summarily ordered by Ho Ch'eng, the army doctor who became the head of Chinese public health, to revert to traditional Chinese methods in treating patients, he said.

Medically these men were ordered back to the Dark Ages—and all were told to plan upon extensive "training" of up to two and a half years in traditional medicine, he said.

continued on page 274



"relief of symptoms is striking with Rautrax-N"†

Rautrax-N decreases blood pressure for almost all patients with mild, moderate or severe essential hypertension. Rautrax-N also offers a new sense of relaxation and well-being in hypertension complicated by anxiety and tension. And in essential hypertension with edema and/or congestive heart failure, Rautrax-N achieves diuresis of sodium and chloride with minimal effects on potassium and other electrolytes.

Rautrax-N combines Raudixin (antihypertensive-tranquilizer) with Naturetin c̄ K (antihypertensive-diuretic) for greater antihypertensive effect and greater effectiveness in relief of hypertensive symptoms than produced by either component alone. Rautrax-N is also flexible (may be prescribed in place of Raudixin or Naturetin c̄ K) and economical (only 1 or 2 tablets for maintenance in most patients).

Supply: Rautrax-N — capsule-shaped tablets providing 50 mg. Raudixin, 4 mg. Naturetin and 400 mg. potassium chloride. *Rautrax-N Modified* — capsule-shaped tablets providing 50 mg. Raudixin, 2 mg. Naturetin and 400 mg. potassium chloride.

†Hutchison J. C.: Current Therap. Res. *2*:487 (Oct.) 1960.

For full information, see your Squibb Product Reference or Product Brief.

Rautrax-N*

Squibb Standardized Rauwolfia Serpentina Whole Root (Raudixin) and Bendroflumethiazide (*Naturetin) with Potassium Chloride

SQUIBB *Squibb Quality — the Priceless Ingredient*

SQUIBB DIVISION Olin

'RAUDIXIN'®, 'RAUTRAX'®, AND' NATURETIN'® ARE SQUIBB TRADEMARKS.

THROUGH THE MICROSCOPE

continued from page 272

Traditional medicine, practiced for centuries in China, employs acupuncture, lancing the skin, muscle or other tissue with a long silver needle; the use of herbs, said to cure everything from appendicitis to fractures; breath control, and shadow boxing, Gonzalez said. The traditional practitioners blame internal diseases on the "seven passions" and external diseases on "six excesses," he said.

Until 1958, traditional practitioners worked side by side with Western-trained physicians, he said, and then the hammer fell.

"The 'new' Chinese theories of medicine read like an allegory out of the time of Charlemagne heavily laden with Marxist dialectic," Gonzalez said.

In a recent Red Chinese medical journal, he said, specialists were accused of hindering the development of science and patients were told to "establish revolutionary optimism and fight their diseases with strong will power."

"Politics intrude on every diagnosis," he continued.

"The most common ailments, affecting perhaps 70 per cent of all patients, are dropsy and liver inflammation, caused by malnutrition and vitamin deficiency. But labeling the diseases for what they are labels a doctor as a 'rightist.' Surely he can't believe there's malnutrition in the people's paradise? Is the patient possibly malingering?"

The Party Line also preaches that Western physicians study medicine with the aim of gaining personal fame and profit, he said.

This is one of the reasons why Chinese medical men have cut their ties with Western medicine so completely that even faced with a massive cholera epidemic on the mainland they could not bring themselves to communicate the simple facts of the case to their Western colleagues beyond the Bamboo curtain, he said.

"Seldom in history has a medical profession so reversed the course of progress as has medicine in Red China today," Gonzalez said.

"When one realizes that this profession serves the world's most populous country, one can envision an eventual medical disaster which could make last year's 50,000 cholera deaths seem like a mere drop in the bucket.

"Attempting to evaluate the impact on the world of China's great leap backward in medicine is almost impossible. If the Reds persist in ignoring epidemics and hiding their presence from the rest of the unsuspecting world it is not impossible to foresee some future disaster outside the Bamboo Curtain.

"But even if the free world escapes the perils of Chinese practice, what about the fate of the 600 million Chinese who today are being treated by perhaps the most undertrained, medievally oriented, and politically infected medical profession in the world? It is their plight which commands our sympathy and their fate which makes China's great leap backward in medicine the terrible human tragedy which it appears to be."

Insurance Groups Oppose Hospital Association Old Age Plan

The American Life Convention, the Health Insurance Association of America, and the Life Insurance Association of America have issued a statement concerning the recent proposal of the American Hospital Association for a new federally-subsidized health care program for the elderly, citing that:

"The AHA's statement, however, also proposes a new federal subsidy for old-age health care, to be superimposed upon the subsidies already provided by the Kerr-Mills Act and by the states. Such a proposal is as fundamentally objectionable as the King-Anderson Bill because it, too, is unnecessary and requires federal subsidy. Of equal importance, it would provide the proposed additional benefits under the administration of a single insurance organization, the Blue Cross. We regret that the proposal would thus tend toward a self-serving insurance monopoly financed with federal funds, which manifestly would not be in the public interest.

continued on page 277

LIFE INSURANCE or DEATH INSURANCE?

SOME Medical men need DEATH Insurance ONLY.

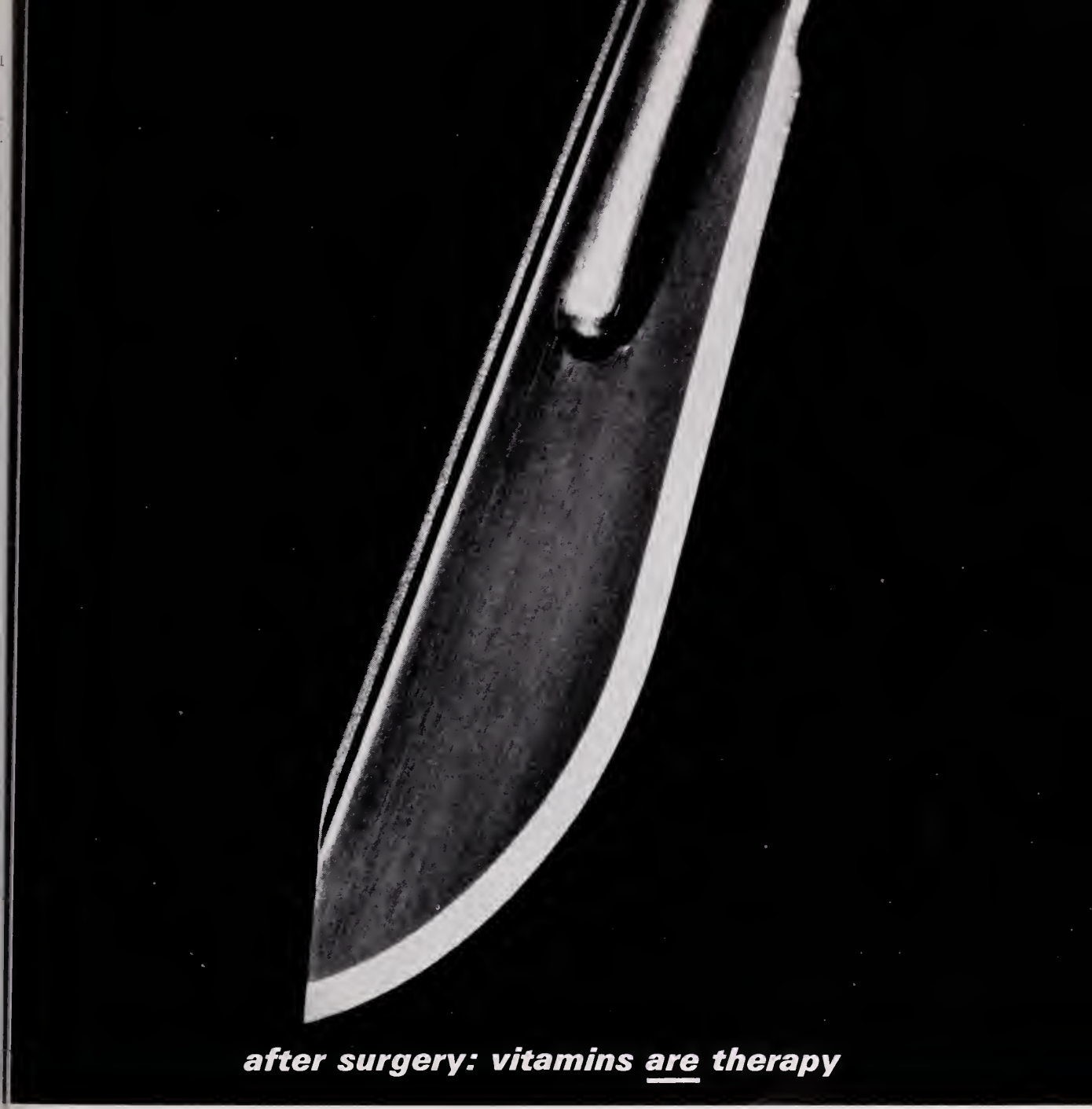
Others need accumulating, guaranteed dollar values to meet their LIVING needs in the future — DEPRESSION — EMERGENCY — RETIREMENT, etc.

In any event, our new "CHEAPER-THAN-TERM" DEATH INSURANCE is the first step in the right direction!

Don't make any important changes in your Life Insurance or Estate plans without investigating "CHEAPER-THAN-TERM"!

For further information about this sensational new development in DEATH INSURANCE, write or phone:

ROLAND A. DEROSIER
32 Custom House Street
Providence 3, Rhode Island
GA 1-1391



after surgery: vitamins are therapy

Nutritional supplementation is basic to postoperative care. Therapeutic allowances of B and C vitamins help meet increased metabolic requirements and compensate for stress depletion. STRESSCAPS can set the patient on a more favorable course and contribute to full recovery. Packaged in decorative "reminder" jars of 30 and 100.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

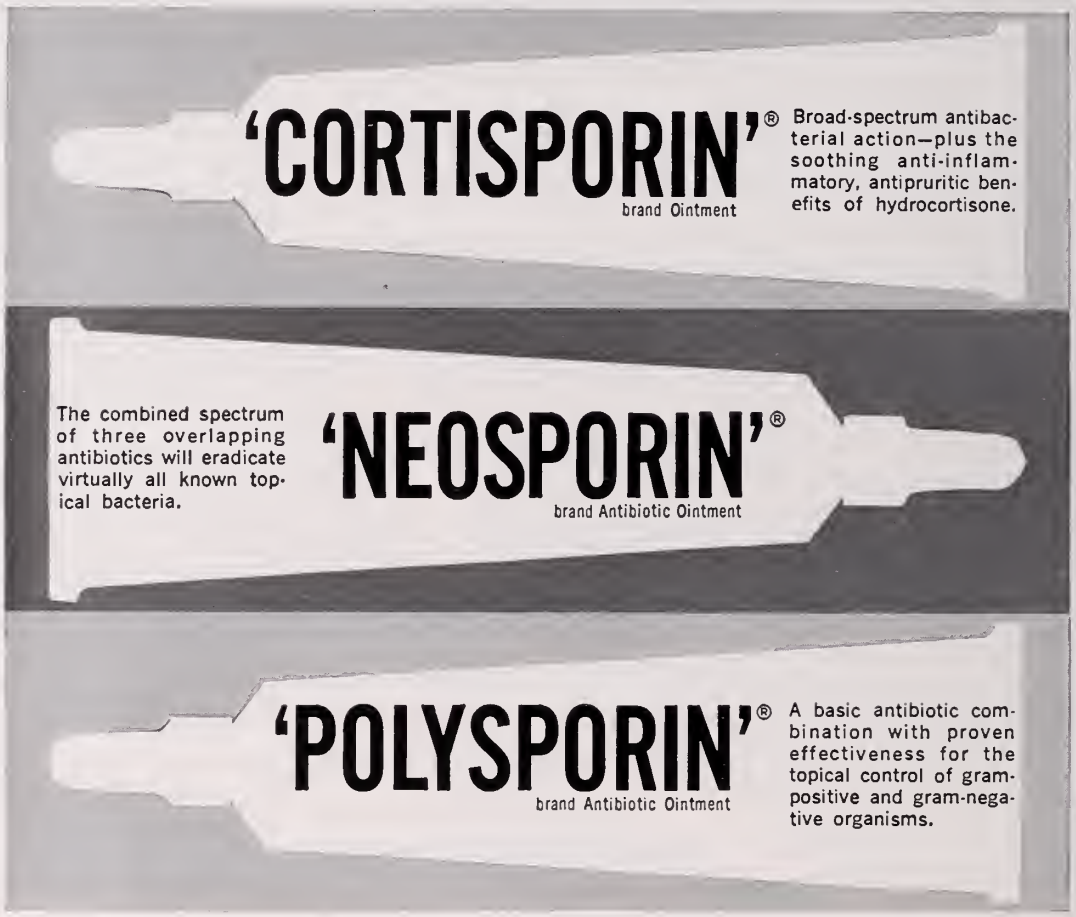
Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

STRESSCAPS®

Stress Formula Vitamins Lederle

'B. W. & Co.' 'Sporin' Ointments rarely sensitize . . . give decisive bactericidal action for most every topical indication



Contents per Gm.	'Polysporin'®	'Neosporin'®	'Cortisporin'®
'Aerosporin'® brand Polymyxin B Sulfate	10,000 Units	5,000 Units	5,000 Units
Zinc Bacitracin	500 Units	400 Units	400 Units
Neomycin Sulfate	—	5 mg.	5 mg.
Hydrocortisone	—	—	10 mg.
Supplied:	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of ½ oz. and ⅛ oz. (with ophthalmic tip)

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

THROUGH THE MICROSCOPE

continued from page 274

"Monopoly in any form tends to stifle experimentation in the expansion and improvement of any product, or service, including health insurance. The spectacular growth in the proportion of the aged population covered by health insurance and the tremendous improvements made in the quality of coverages during the past decade can be attributed directly to the competition among the various types of insurers, including Blue Cross. This has been to the continuing benefit of all the people and any change in the system, we feel, would not be in the best interests of the public.

"The health care needs of the aged can be adequately met through a combination of voluntary insurance and the subsidized benefits provided for the medically indigent by the Kerr-Mills Act and the states. Voluntary insurance is now carried by more than half the population 65 years of age and over as a matter of personal responsibility and is continuing to expand. The AHA's proposal would terminate this growth and would supplant this coverage in large measure with a government-subsidized program.

Rhode Island Physicians Honored

Doctor Wesley W. Spink, professor of medicine at the University of Minnesota Medical School and an outstanding authority on infectious diseases, has been selected as president-elect of the American College of Physicians at the business meeting of the College.

Doctor Spink will serve as the 1963-64 president of the College which represents 11,000 internists and specialists in related fields. Doctor Franklin M. Hanger, Staunton, Virginia, assumed the presidency of the forty-seven-year-old organization for 1962.

The physicians also elected Doctor Marshall N. Fulton, Providence, Rhode Island, as first vice president; Doctor Paul H. Revercomb, Charleston, West Virginia, second vice president, and Doctor Willis M. Fowler, Iowa City, Iowa, third vice president.

Newly elected to the Board of Governors of the American College of Physicians were Doctor William B. Bean, Iowa City, Iowa; Doctor Jarrett H. Folley, Hanover, New Hampshire; Doctor Irving A. Beck, Providence, Rhode Island, and Doctor Robert Clark Dickson, Halifax, Nova Scotia.

* * *

At the Annual Meeting of the New England States Chapter of the American College of Chest Physicians held at the Boston City Hospital on March 31, 1962, the following officers were elected: President, Peter F. Harrington, M.D., Providence, Rhode Island; first vice president, David P. Boyd, M.D., Boston, Massachusetts; second vice president, Frank Davis Gray, Jr., M.D., Woodbridge, Connecticut; and secretary-treasurer, Samuel Clive Cohen, M.D., Boston, Massachusetts.

Blue Plans Direct Enrollment Again a Success

More than 13,000 persons joined Blue Cross and Physicians Service during the open enrollment period that ended in April.

The preliminary results of the campaign topped the previous open enrollment drive, held in 1959, by more than 600 members. Membership was offered to all persons in the state on a non-group basis during the campaign.

"This was one of the most successful drives in the history of the plans, and clearly demonstrates the confidence of Rhode Islanders in the Blue Cross and Physicians Service plans," Mr. Hanley, executive director, stated. "The results are even more significant during a period of relatively high employment when more persons already have group membership, and considering that there is a smaller percentage of the population who are not yet members."

The plan official also reported that group membership is at an all-time high, and the addition of the new members will boost the plan enrollment to probable new highs of almost 660,000 Blue Cross members and nearly 600,000 Physicians Service members.

Experimental Preceptorship Program Announced

An experimental preceptorship program to acquaint outstanding junior and senior medical students with the elements of general practice work in small communities will be sponsored in 1962 by The Sears-Roebuck Foundation in co-operation with the Student American Medical Association Foundation.

According to James T. Griffin, Foundation president, and Doctor Walter L. Portteus, chairman of the Foundation's Medical Advisory Board, the pilot program for 1962 calls for locating eight medical students in communities which have successfully participated in the Foundation's Community Medical Assistance Program.

Scholarships of $500 will be made to students who spend two consecutive months during the current year studying and working with doctors in these communities, they said.

In addition, the communities themselves will provide the students with free food and lodging during their two-month residencies.

Students selected to work in Foundation communities will report their experiences in articles to be published in the JOURNAL OF THE STUDENT A.M.A., Griffin and Portteus said. Purpose of the program is to interest medical students in the opportunities afforded by general practice.

BOOK REVIEWS

METABOLIC EFFECTS OF ADRENAL HORMONES in honour of Prof. G. W. Thorn. Ciba Foundation Study Group No. 6. Editors: G. E. W. Wolstenholme and Maeve O'Connor. Little, Brown & Co., Bost., 1961; Lond., 1960. $2.50

The "news and views" on this limited subject are published in full including the discussion as presented at the conference under the same name, sponsored by Ciba and prompted by Thorn's 1960 visit to England, accompanied by several of his research staff. The conference included papers by Thorn's group as well as by English researchers. Except for subject and material, this volume 6 is similar to the earlier Study Group series.

Adrenal hormone effect on carbohydrate, protein, and fat metabolism is covered along with the intermediary role of the liver. Clinical interest is related to the clear demonstration, on the laboratory level, of the catabolic effect of Cortisol® on protein, the clearly demonstrated antagonism to insulin, and the gluconeogenic effect acting through the liver.

Cahill's paper again shows that despite active interest in fat metabolism and much clarification, many simple riddles, such as obesity itself, and patterns of fat distribution, such as occurs in Cushing's disease, remain. Local effects of Cortisol® in both laying down fat and depleting fat have been observed.

This volume contains more clinical material than former numbers, being a report by men who are clinicians as well as scientists.

R. V. Lewis, M.D.

PATHOLOGIC PHYSIOLOGY. Mechanisms of Disease. Edited by William A. Sodeman, M.D. Third edition. W. B. Saunders Co., Phil., 1961. $15.00

Pathologic Physiology is, in format and authorship, a textbook of medicine. Symptoms and signs of disease are treated as resultants of disordered physiologic mechanisms. A conventional modern text of medicine traditionally (1) defines a disease, (2) discusses etiologic agents, (3) describes anatomical changes, (4) records the natural history, (5) enumerates signs and symptoms, and (6) advises current therapy. This new edition of Sodeman, like the previous issues, focuses on signs and symptoms and the studies of their production as disordered physiology. The other considerations are discussed only as necessary for intelligent discussion of the disorders of physiology. Intensive exposition of disordered function is of considerable value to a clinician concerned with disease.

The contributors are physicians, not physiologists or pathologists, and this clinical interest makes their studies vital, not academic. Several are contributors to the conventional textbooks of medicine where they have discussed their subjects more generally. The exposition is good and fairly well edited, but, as with all bulky texts of pleural authorship, perfect balance and quality is impossible.

The first chaper on genetics summarizes the extensive recent results, and puts first things first.

This book should be a companion to a general text. The title should be more descriptive of the contents. Since this is the third edition such a change is unlikely in the future. Despite the title, internists and practitioners should familiarize themselves with this book. It is written by internists with narrow interests for internists with broad interests.

R. V. Lewis, M.D.

CLINICAL DISTURBANCES OF RENAL FUNCTION by Abraham G. White, M.D. W. B. Saunders Co., Phil., 1961. $10.50

"Kidney disease, pathology, physiology, pathophysiology, and miscellaneous items of clinical interest" would be a better descriptive title for this very good textbook. It is replete with excellent, well designed, and clever diagrams. Photographs add further to the technique of good textbook design.

White has included all aspects of the kidney as a clinical subject which have interested him and should interest every physician. Only experience in teaching and a gift of teaching ability could produce the clear descriptive figures he presents.

A renal physiology section is followed by one on primary renal disease. Then the entire list of conditions with a secondary renal factor is discussed, such as the kidney in obstetrics, in endocrinology, and in genetics. A final chapter even considers the comparative anatomy of the kidney.

concluded on page 280

TESTIMANIMAL



An epicure's delight!

WARWICK CLUB
GINGER ALE

It sings in the glass



One Caution When You Buy Mink...



Consult a reliable furrier who is interested in protecting your interests, with honest value and guaranteed quality. Come to Harris, and buy with confidence!

WILLIAM H. *Harris*

New England's Largest Exclusive Furrier
400 Westminster Street
Our 2nd Half-Century of Fine Fur Tradition



Wherever you go forget your telephone calls. We'll take them for you, day or night.

MEDICAL BUREAU
of the
Providence Medical Association

BOOK REVIEWS

concluded from page 278

A first book tries to do all. The dedication to "wife, children, and parents" suggests that White is going to give his all in the succeeding pages. The "all" is worthy of the writing. If it is perhaps profuse, it is also well organized, well illustrated, and very suitable for teaching.

R. V. Lewis, M.D.

COMMON SENSE ABOUT PSYCHOANALYSIS by Rudolph Wittenberg, M.D. Doubleday & Co., Inc., Garden City, N. Y., 1962. $3.95

Doctor Wittenberg writes about one form of psychotherapy, the one developed by Freud and named by him "psychoanalysis." Discussion of theory and the technical aspects are omitted in this book for the layman.

Popular questions concerning psychoanalysis are answered very well by this practicing psychoanalyst who addresses himself to the intelligent reader.

The method of choosing an analyst is a revealing chapter. The doctor covers thoroughly the controversial issues concerning the selection of an analyst therapist whether trained originally as a physician or as a therapist.

Daniel D. Young, M.D.

THE CERVIX UTERI AND ITS DISEASES by C. Frederic Fluhmann, M.D. W. B. Saunders Co., Phil., 1961. $14.00

This is a comprehensive and up-to-date text that presents in one volume material that formerly was available only in several. The book is divided into six sections: 1) *The Normal Cervix* including embryology, gross and microscopic anatomy, and physiology; 2) *Diagnostic Procedures* including all current methods; 3) *Congenital Anomalies, and Traumatic and Functional Disorders;* 4) *Inflammatory Diseases;* 5) *New Growths;* and 6) *Pregnancy.*

The chapters on *Invasive Carcinoma, Treatment, and Radiotherapy* are especially good and provide a current survey of the subject that covers all aspects. Since this book is intended for the practicing clinician special attention has been given to clinical manifestations, diagnosis, treatment, and complications.

The two aspects of Doctor Fluhmann's book which are most outstanding are the bibliographies and the illustrations. The bibliography at the end of each chapter is extensive and contains the latest (up to 1961) references by the authors. The drawings and photomicrographs are many and of the highest quality.

This volume is recommended as an excellent reference book and for its up-to-date bibliographies.

Marshall A. Taylor, M.D.

CURRENT THERAPY, 1962. Latest Approved Methods of Treatment for the Practicing Physician. Edited by Howard F. Conn, M.D. W. B. Saunders Co., Phil., 1962. $12.50

In each annual edition new experts in the respective fields give details of their preferred methods of therapy. This represents an up-to-date authoritative collection of therapeutic suggestions.

This 1962 edition is again highly recommended.

F. Ronchese, M.D.



Fuller

Memorial Sanitarium

Located on Rt. 1

South Attleboro, Massachusetts

A modern non-profit hospital for the care and treatment of nervous and emotional disorders as well as long term geriatric problems.

Physical, neurological, psychiatric and psychological examinations.

Modern recognized psychiatric therapies.

A pleasant homelike atmosphere in a beautiful and conveniently located institution.

L. A. Senseman, M.D., F.A.P.A., Medical Director
Edwin Dunlop, M.D. Michael G. Touloumtzis, M.A.
Oliver S. Lindberg M.D. William H. Dunn, M.S.W.
W. H. Lesovsky, M.D., Ph.D.

Referred patients are seen daily (except Saturdays) 9-12 A.M., and by appointment.
R. I. Blue Cross Benefits Tel. Southgate 1-8500

Special Rates for Long-Term Care

Curran & Burton, Inc.

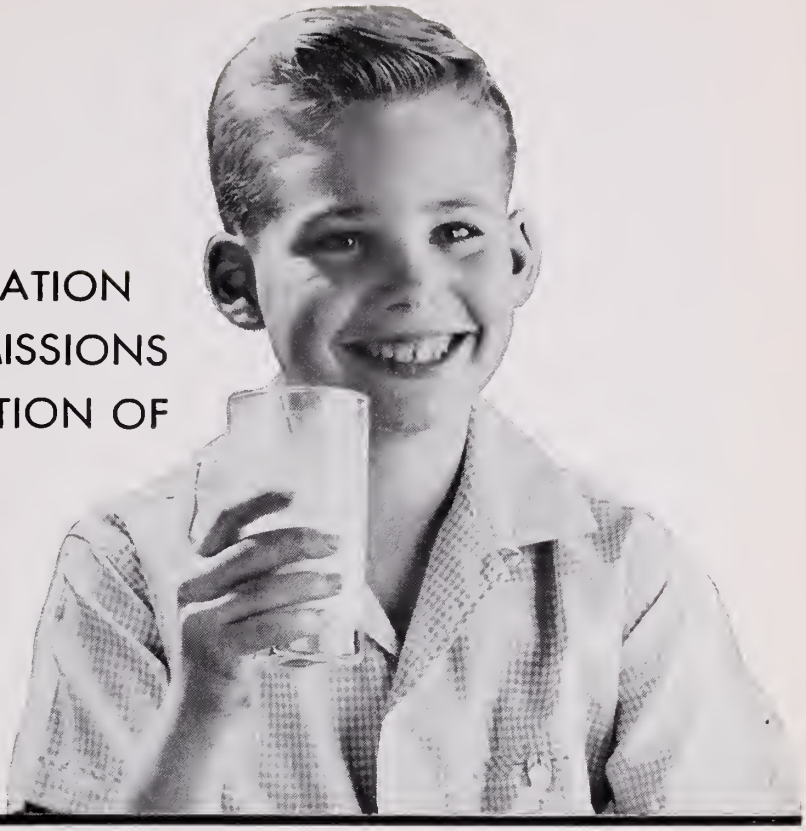
INDUSTRIAL
AND WHOLESALE

COAL **OIL**

17 CUSTOM HOUSE STREET
PROVIDENCE, R. I.
DExter 1-3315

THE AMERICAN ASSOCIATION
OF MEDICAL MILK COMMISSIONS
SUPERVISES THE PRODUCTION OF

Certified MILK



1. CLEANER. Lowest bacteria-count. Milk checked before each milking. All utensils, bottles, and equipment sterilized before use.

2. BETTER-PROTECTED. Strictest medical supervision of herds and employees. Frequent examinations and laboratory-control AT THE FARM are required.

3. AUTOMATIC MILKING. Cows are milked automatically by electric machine. Milk is bottled without exposure to air or human touch.

4. BOTTLE CLOSURES. Must be of the highest quality to provide complete protection for the milk and bear approval of The American Association of Medical Milk Commissions.

5. MORE NUTRITIOUS. Cows scientifically fed balanced ration. Nutrition control from soil to delivery of milk. Same diet all year.

6. LONGER-LASTING, BETTER-TASTING. Diet control, special handling, and shortest time of delivery from cow to consumer assure fine fresh flavor that lasts for weeks.

7. THE DOCTOR'S MILK. Produced, processed, bottled on farms supervised by Medical Milk Commissions. Each bottle bears the seal of the A.A.M.M.C. and names of the supervising Commission and producing farm.

MILK COMMISSION OF PROVIDENCE MEDICAL ASSOCIATION

HILLSIDE FARMS, INC., 1308 Phenix Ave., Cranston, WI 2-3400
Produced at Hillside Farm, Cranston, R. I.

H. P. HOOD & SONS, 135 Harris Ave., Providence, DE 1-3024
Produced at Hood Certified Farm, Beverly, Mass.

WHITING MILK CO., 40 Tockwotton St., Providence, GA 1-5363
Produced at Hampshire Hills Farm, Wilton, N. H.



To help you and your family build systematically and surely for the future

A new type of trust service from Industrial National Bank

THE BUDGET TRUST

NOW INDUSTRIAL NATIONAL offers you a personal budget plan to help you build for the future — a budget plan you can start on right now! It's a new type of trust service — *The Budget Trust.*

How your Budget Trust works

You start your Budget Trust with $100 or more. Then you make regular planned deposits. It may be as little as $25 a month.

Your funds are invested in common stocks selected primarily with an eye to long-term growth rather than current income. Your lawyer draws the Trust Agreement — and Industrial National acts as your trustee. All income earned is added to your Budget Trust and reinvested. The continuous inflow of funds gives you the maximum advantage of dollar-cost-averaging.

Flexibility of your Budget Trust

Your Budget Trust is revocable at any time, in part or in whole. You may withdraw any part of your funds on quarterly withdrawal and entry dates.

You will discover, though, that a Budget Trust — with its systematic deposit feature — will make it much easier for you to accumulate the funds you need for your long-range goals. It's something important to consider when you think ahead to your retirement, your children's education, or any other years-from-now project.

Your Budget Trust brings you the benefits of Industrial National's broad investment and trust experience. One of our trust officers will be glad to discuss the new Budget Trust with you. To learn more about the Budget Trust, visit any Industrial National office, or call Mr. Allingham at JA 1-9700.

INDUSTRIAL
NATIONAL BANK OF
RHODE ISLAND

45 Neighborhood Offices Serving Rhode Island

Member Federal Reserve System
Member Federal Deposit Insurance Corporation

JUNE, 1962

RHODE ISLAND

Medical Journal

LIBRARY
JUL - 7 1962
NEW YORK ACADEMY
OF MEDICINE

Volume XLV, No. 6

Table of Contents, page 283



sign of infection?



symbol of therapy!

Ilosone® is available in three convenient forms: Pulvules®—125 and 250 mg.*; Oral Suspension—125 mg.* per 5-cc. teaspoonful; and Drops—5 mg.* per drop, with dropper calibrated at 25 and 50 mg.

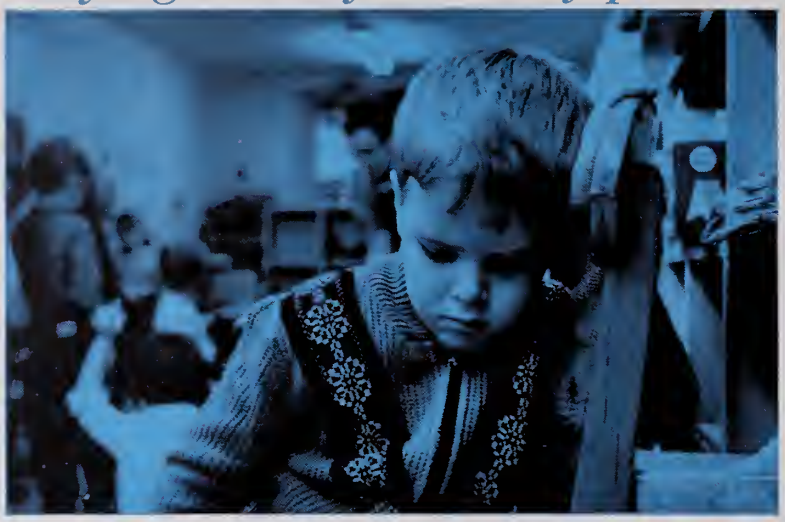
This is a reminder advertisement. For adequate information for use, please consult manufacturer's literature. Eli Lilly and Company, Indianapolis 6, Indiana. Ilosone® (erythromycin estolate, Lilly) *Base equivalent

Lilly

232633

Ilosone works to speed recovery

"crying solitary in lonely places"



DILANTIN®

(diphenylhydantoin, Parke-Davis)

permits a richer life for the epileptic

"It has been more than twenty years since the introduction of diphenylhydantoin sodium (DILANTIN Sodium) as an anticonvulsant substance. This drug marks a milestone in the rational approach to the management of the epileptic."[1] In grand mal and psychomotor seizures, DILANTIN is a drug of choice for a variety of reasons: • effective control of seizures[1-9] • oversedation is not a common problem[2] • possesses a wide margin of safety[3] • low incidence of side effects[3] • its use is often accompanied by improved memory, intellectual performance, and emotional stability.[10] DILANTIN (diphenylhydantoin, Parke-Davis) is available in several forms, including DILANTIN Sodium Kapseals,® 0.03 Gm. and 0.1 Gm., bottles of 100 and 1,000. Other members of the PARKE-DAVIS FAMILY OF ANTICONVULSANTS for grand mal and psychomotor seizures: PHELANTIN® Kapseals (Dilantin 100 mg., phenobarbital 30 mg., desoxyephedrine hydrochloride 2.5 mg.), bottles of 100. for the petit mal triad: MILONTIN® Kapseals (phensuximide, Parke-Davis) 0.5 Gm., bottles of 100 and 1,000; Suspension, 250 mg. per 4 cc., 16-ounce bottles. CELONTIN® Kapseals (methsuximide, Parke-Davis) 0.3 Gm., bottles of 100. ZARONTIN® Capsules (ethosuximide, Parke-Davis) 0.25 Gm., bottles of 100.

This advertisement is not intended to provide complete information for use. Please refer to the package enclosure, medical brochure, or write for detailed information on indications, dosage, and precautions.

REFERENCES: (1) Roseman, E.: Neurology **11**:912, 1961. *(2) Bray, P. F.: Pediatrics* **23**:151, 1959. *(3) Chao, D. H.; Druckman, R., & Kellaway, P.: Convulsive Disorders of Children, Philadelphia, W. B. Saunders Company, 1958, p. 120. (4) Crawley, J. W.: M. Clin. North America* **42**:317, 1958. *(5) Livingston, S.: The Diagnosis and Treatment of Convulsive Disorders in Children, Springfield, Ill., Charles C Thomas, 1954, p. 190. (6) Ibid.: Postgrad. Med.* **20**:584, 1956. *(7) Merritt, H. H.: Brit. M. J.* **1**:666, 1958. *(8) Carter, C. H.: Arch. Neurol. & Psychiat.* **79**:136, 1958. *(9) Thomas, M. H., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, The Williams & Wilkins Company, 1956, pp. 37-48. (10) Goodman, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 187.*

PARKE-DAVIS

92462 PARKE, DAVIS & COMPANY Detroit 32, Michigan





A DRAMATIC EXPANSION OF TRUST SERVICE

Here and now . . . with the . . . INSTALLMENT TRUST

Now, estates can be built month by month under the experienced, able trusteeship of New England's oldest Trust Company.

Professional and business men can build in trust for *retirement . . . college educations for their children . . . added family security.*

You can begin an *Installment Trust* with as little as $100. Monthly additions as low as $25. Partial or complete withdrawals can be made at any time.

An informative leaflet is yours for the asking. Simply fill in and mail the coupon.

RHODE ISLAND
HOSPITAL TRUST COMPANY

RHODE ISLAND HOSPITAL TRUST COMPANY
15 Westminster Street, Providence 1, Rhode Island

Please send me a copy of "THE INSTALLMENT TRUST" leaflet

NAME .....

ADDRESS .....

.....



Wherever you go forget your telephone calls. We'll take them for you, day or night.

MEDICAL BUREAU

of the

Providence Medical Association

The RHODE ISLAND MEDICAL JOURNAL

Editorial and Business Office: 106 Francis Street, Providence, R. I.

Editor-in-Chief: SEEBERT J. GOLDOWSKY, M.D.

Managing Editor: JOHN E. FARRELL, SC.D.

Senior Editors

ALEX M. BURGESS, SR., M.D. HENRI E. GAUTHIER, M.D.

Advisory Board

(in addition to editors listed above)

JOHN A. DILLON, M.D. JOHN F. W. GILMAN, M.D. ROBERT V. LEWIS, M.D.
PETER L. MATHIEU, M.D. JOSÉ M. RAMOS, M.D. ROBERT W. RIEMER, M.D.
JACK SAVRAN, M.D. LESTER L. VARGAS, M.D.

Owned and Published Monthly by
THE RHODE ISLAND MEDICAL SOCIETY
Second-class postage paid at Providence, Rhode Island
Copyright, 1962, the Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island
Single copies, 25 cents . . . Subscription, $2.00 per year.

Volume XLV, No. 6 June, 1962

TABLE OF CONTENTS

PAGE

THE DOCTOR'S IMAGE—PAST, PRESENT, AND FUTURE, *Samuel Adelson,* M.D. 297

HUMAN DESTINY'S NEW DIMENSIONS, *Hon. John O. Pastore* 299

MEDICAL EDUCATION AND BROWN UNIVERSITY, *Glidden Brooks,* M.D. 301

TRANSIENT DYSPROTEINEMIA IN INFANTS, *Jay Orson,* M.D. 305

EDITORIALS

Actions — Not Words 311

Town and Gown 311

The Sesquicentennial Meeting 312

DEPARTMENTS

Book Reviews 292

General Meeting, Rhode Island Medical Society 307

Society Officers Installed 308

Honorary Memberships Awarded 309

House of Delegates, Rhode Island Medical Society, Report of April 30, 1962 Meeting 314

District Medical Society Meetings 328

MISCELLANEOUS

Health and Welfare Legislation in Rhode Island, 1962 286

Exposition of Health Progress Photos 310

Index of Advertisers 332

LIFE INSURANCE or DEATH INSURANCE?

SOME Medical men need DEATH Insurance ONLY.

Others need accumulating, guaranteed dollar values to meet their LIVING needs in the future — DEPRESSION — EMERGENCY — RETIREMENT, etc.

In any event, our new "CHEAPER-THAN-TERM" DEATH INSURANCE is the first step in the right direction!

Don't make any important changes in your Life Insurance or Estate plans without investigating "CHEAPER-THAN-TERM"!

For further information about this sensational new development in DEATH INSURANCE, write or phone:

ROLAND A. DEROSIER
32 Custom House Street
Providence 3, Rhode Island
GA 1-1391



Fuller

Memorial Sanitarium

Located on Rt. 1

South Attleboro, Massachusetts

A modern non-profit hospital for the care and treatment of nervous and emotional disorders as well as long term geriatric problems.

Physical, neurological, psychiatric and psychological examinations.

Modern recognized psychiatric therapies.

A pleasant homelike atmosphere in a beautiful and conveniently located institution.

L. A. Senseman, M.D., F.A.P.A., Medical Director
Edwin Dunlop, M.D. Michael G. Touloumtzis, M.A.
Oliver S. Lindberg, M.D. William H. Dunn, M.S.W.
W. H. Lesovsky, M.D., Ph.D.

Referred patients are seen daily (except Saturdays) 9-12 A.M., and by appointment.
R. I. Blue Cross Benefits Tel. Southgate 1-8500

Special Rates for Long-Term Care

Excerpts From . . .

LOOK WHO'S USING A MEANS TEST!

By EDWARD R. ANNIS, M.D.

Should we subject our senior citizens to a means test when they apply for tax-paid health benefits? "No!" says Nelson Cruikshank, head of the AFL-CIO's Social Security division—and he keeps on saying it. So do other labor leaders and liberal politicians. For example, in Hawaii the opponents of Kerr-Mills implementation loudly decry the "degrading" means test that this law demands. Apparently this reflects a co-ordinated campaign by proponents of socialized medicine for the aged.

How *can* we doctors best answer this raw political sophistry? I'd say by simply pointing to the economic, social, and political organizations all over the country that use a means test routinely without anyone thinking it's degrading. The biggest example of all is the Federal Government itself.

Consider federal housing projects. Applicants must meet rigid income qualifications set by local federal authorities. In Chicago, a single person can't earn more than $3,600 and live in a public housing project.

Certainly V.A. hospitals have a means test.

One more government example: In a recent message to Congress, President Kennedy advocated scholarships for deserving college students unable to pay their own way. Presumably their degree of need must be determined by a means test. How else?

But the government is hardly the only organization that insists on some proof of need before disbursing funds. Other very large ones do it—labor unions, for example.

In long strikes, some unions distribute cash to their members according to individual needs.

The June 30, 1960, annual report of the United Mine Workers Welfare and Retirement Fund has in it some highly pertinent passages. Here's one: "The determination of eligibility is made with scrupulous adherence to regulations of the Trustees."

And look at health insurance plans. As every physician knows, many of these plans scale their benefits according to income—clearly implying some form of means test.

A list of organizations that routinely check on ability to pay could go on and on. This plainly establishes the fact that the means test is used without shame in many areas of our national life.

Why on earth should it be held "degrading" when associated with tax-paid medical care?

. . . Reprinted from the DETROIT MEDICAL NEWS, March 5, 1962

Patronize Journal Advertisers



A new answer to one of America's leading health problems

60 DELICIOUS FOODS THAT MAKE WEIGHT CONTROL EASIER!

Here is a practical and down-to-earth method to help overcome obesity, the nation's No. 1 diet problem—and prime stealer of doctor's consultation time. Now a new group of 60 delicious Mott's Figure Control Food products uses the best of nutrition knowledge to create quality dishes, lower in calories by an average of 50%. Indicated calorie savings can be made pleasantly and accurately while eating normal-size portions by using these calorie-controlled foods in place of higher calorie dishes. Protein, vitamin and mineral food values are retained.

Low carbohydrate, low fat: Fats are largely extracted from meats and poultry in a way that cannot be done at home. Sauces and dressings are prepared with a high proportion of non-fat milk solids, vegetable colloids, all are delectably "natural" and tempting in flavor. Fruits, juices, desserts and sauces are prepared where indicated with non-caloric sweeteners—natural fruit values are intact, extra sugars reduced. The carbohydrate, protein and fat content appears on all labels along with the calorie count. Useful for diabetic diets, too.

Easy medical tool for doctors: Less need for drugs, no possible dangerous side effects, not even temporary dislocation of meal patterns. Figure Control Foods include: Soups, Meats & Poultry, Popular Sauces, Salad Dressings, Preserves, Syrup, Fruits, Drinks, Desserts and Sweeteners.

New Mott's Figure Control® Foods offer Good Eating at Half the Usual Calories

	Quantity	Figure Control Calories	"Regular" Food Calories
Apple-Grape Drink	½ cup	20	52
Five-Fruit Juice Breakfast Drink	½ cup	20	52
Braised Beef and Vegetables	6½ oz.	184	380
Meat Balls in Brown Gravy	3½ oz.	84	280
Chopped Chicken Livers	1 oz.	31	100
Chicken a la King	3 oz.	72	230
French Style Dressing	1 tbsp.	10½	60
Brown Gravy	1 tbsp.	7	21

	Quantity	Figure Control Calories	"Regular" Food Calories
Applesauce	½ cup	48	90
Fruit Cocktail	½ cup	44	90
Cherry Pie Filling	1 oz.	20	60
Chocolate Topping	1 tbsp.	8	63
Preserves (Peach, Strawberry)	1 tbsp.	9	55
"Maplette" Syrup	1 tbsp.	9	55
Liquid or Powder Sweetener	(to equal 1 tbsp. of sugar)	0	16



Complete menus, recipes, calorie chart available for professional distribution, with weight control guides you can distribute with confidence: all menus meet N.R.C. Recommended Daily Allowances. **Use this handy order form:**

FIGURE CONTROL FOODS
Duffy-Mott Company
370 Lexington Avenue
New York 17, New York

Please send____free copies of YOUR WEIGHT CONTROL PLAN for use with patients.

Dr._____

Address:_____

City:_____ Zone:____ State:_____

HEALTH AND WELFARE LEGISLATION

The Rhode Island General Assembly, January Session, 1962

Legislation Enacted

AGED MEDICAL CARE. H-1651. A resolution endorsing President John F. Kennedy's medical care for the aged program. Passed House, March 29; passed Senate, March 30; signed by governor: April 4.

AUTO SAFETY. H-1248-A. Requires seat belts on all new automobiles beginning with 1964 models. Signed: April 17.

BLOCK ISLAND. H-1123. A resolution requesting the governor to appoint a special committee to conduct a survey to determine the urgent need for a resident physician and adequate medical facilities in the town of New Shoreham (Block Island). Signed: February 5.

(The Commission was appointed and it made a report to the governor.)

H-1496. A bill authorizing the state director of health, with the approval of the governor, to request state-employed physicians to accept assignment on Block Island whenever there is a doctor shortage there, and allowing them to retain, in addition to their regular state pay, a proportion of the fees collected on the Island as may be prescribed by the director. Signed: April 20.

BLOODMOBILE. S-259. A resolution appropriating $3,000 for the operation of the Rhode Island American Legion's bloodmobile. Signed: April 19.

CHIROPRACTORS. S-344. A bill defining the meaning of "gross unprofessional conduct" in the law concerning the suspension and revocation of a chiropractor's license. Signed: April 17.

EVIDENCE: S-234. A bill providing that in personal injury suits, a sworn statement from a physician, dentist or authorized agent of a hospital can be admitted in evidence of the charges for services rendered. Signed: April 21.

HOSPITAL. H-1603. A bill providing reimbursement of $16,073 for the fiscal year ending September 30, 1960, and $8,432 for the fiscal year ending September 30, 1961, to Rhode Island Hospital for providing acute medical and surgical care to public ward patients. Signed: April 19.

HOUSING. H-1108-A. A bill amending the Providence Minimum Standards Housing Act to authorize the city council by ordinance to require, among other things, hot water facilities in addition to certain specified fixtures in dwellings. Signed: April 18.

INJURIES. H-1260. A bill requiring a 30-day waiting period from date of injury before a settlement release may be negotiated. Signed: April 21.

INSURANCE. H-1691. A bill exempting accident and sickness insurance policy benefits from attachment. Signed: April 20.

KENT COUNTY. S-151. A resolution upon the death of Doctor Fenwick G. Taggart of East Greenwich, a past Vice President of the Rhode Island Medical Society. Passed in concurrence, January 31.

S-199. An act authorizing the Kent County Medical Society to accept the provisions of the will of Doctor Elmer A. Miller who died in 1937 in New York State. Title is given to real estate in the Pawtuxet Valley on which to erect, equip and maintain and operate a non-profit hospital for the physicians and people of Kent County, to be known as the Miller Hospital. Signed: February 26.

MEDICAL EXAMINERS. S-455. An act providing that state medical examiners shall be bonded for $2,000 instead of $1,000. Signed: April 18.

MENTAL HEALTH. H-1072. A bill defining the functions of the state commission to aid the mentally retarded to "explore, consider, and advise on the needs of" mentally retarded persons. Signed: March 13.

H-1162. A resolution directing the legislative council to make a study to determine the feasibility of enacting legislation relative to the mandatory testing of newborns for evidence of mental retardation. Signed: January 30.

H-1228 (A). An act providing for state financial assistance for the establishment of mental health programs by local communities and non-profit corporations. Signed: April 23.

H-1326. An act authorizing the issue of bonds and notes for new facilities for the care and training of mentally retarded children at the Doctor Joseph H. Ladd School. Signed: April 2.

continued on page 288



Welcome to another year of Lederle Symposia

Recognizing that the exchange of ideas is fundamental to medical progress, Lederle continues its Symposium program with the 11th year of scheduled meetings. Through these Symposia, sponsored by medical organizations with our cooperation, over 55,000 physicians have had the opportunity to hear and question authorities on important advances in clinical medicine and surgery. You have a standing invitation to attend any of these Symposia with your wife for whom a special program is planned.

SPOKANE, WASHINGTON
Saturday, June 2, 1962
The Davenport Hotel

BIRMINGHAM, ALABAMA
Saturday, June 2, 1962
Dinkler-Tutwiler Hotel

WASHINGTON, D. C.
Saturday, June 9, 1962
Marriott Motor Hotel

LAND O'LAKES, WISCONSIN
Sunday, June 17, 1962
King's Gateway Hotel and Inn

EAU CLAIRE, WISCONSIN
Wednesday, June 20, 1962
The Eau Claire Hotel

ATLANTA, GEORGIA
Wednesday, July 18, 1962
The Hotel Dinkler Plaza

SAN ANTONIO, TEXAS
Sunday, September 9, 1962
The Granada Hotel

CLARKSBURG, WEST VIRGINIA
Sunday, September 9, 1962
The Stonewall-Jackson Hotel

TYLER, TEXAS
Wednesday, September 12, 1962
Carlton Hotel

KANSAS CITY, KANSAS
Friday, September 14, 1962
Battenfeld Auditorium

WOODSTOCK, VERMONT
Wednesday, September 19, 1962
The Woodstock Inn

NIAGARA FALLS, ONTARIO
Saturday, September 29, 1962
Sheraton-Brock Hotel

RAPID CITY, SOUTH DAKOTA
Saturday, October 6, 1962
Holiday Inn

FINDLAY, OHIO
Thursday, October 11, 1962
The Findlay Country Club

HONOLULU, HAWAII
Sunday, October 21, 1962
The Princess Kaiulani Hotel

NEWARK, NEW JERSEY
Sunday, October 28, 1962
Robert Treat Hotel

SANTA BARBARA, CALIFORNIA
Saturday, November 3, 1962
Santa Barbara Biltmore Hotel

INDIANAPOLIS, INDIANA
Wednesday, November 7, 1962
Marott Hotel

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.

HEALTH AND WELFARE LEGISLATION

continued from page 286

MILK. S-6 (A). An act abolishing the milk control board. Signed: April 17.

S-456. A bill concentrating milk inspection functions in the department of health and adopting a Rhode Island Milk Sanitation Code. Signed: April 17.

NURSES. H-1648. A bill removing the requirements that a registered nurse must be at least 20 years old and a practical nurse 18 years old, and eliminating requirements that members of both the Board of Nurse Registration and Nursing Education and the board's Counselling Committee can serve for no more than two three-year terms. Signed: April 17.

PHARMACY. S-604. A bill removing the administrator of the division of food and drug control from the state board of Pharmacy, providing that the board shall elect its officers annually instead of semi-annually, and requiring the Department of Health to provide administrative services for the board. Signed: April 18.

PHYSICIANS SERVICE. S-11 (A). A resolution creating a special 17-member commission charged with examining the operation of Physicians Service and Blue Cross, the "orderly development" of medical facilities in the state, the means of making medical care available for all the responsibilities of government, and the broad field of hospital construction and administration. The commission has subpoena powers. Of the 8 non-political appointments to the commission, to be made by the governor, one is to be from labor, one from hospitals, one from medicine, one from medical insurance, one from industry, and three from the general public. Signed: March 28.

PHYSICAL THERAPY. H-1427. An act establishing licensure for the practice of physical therapy in Rhode Island. Signed: April 21.

PROFESSIONAL REGULATION. S-501. An act that forbids optometrists to practice in buildings where more than 50% of the space is devoted to a commercial enterprise which advertises its ware, and making other extensive changes in the law regulating optometry.

Effective without the signature of the governor, April 24.

PROFESSIONAL REGULATION. S-545. A bill defining the meaning of "gross unprofessional conduct" in the law concerning the suspension and revocation of a physician's license. Signed: April 17.

S-546. Same as S-545, but applicable to the laws relating to podiatry. Signed: April 17.

PUBLIC HEALTH. H-1126. A bill broadening the definition of camps coming within the inspection authority of the department of health to include mobile homes or other structures, and broadening the definition of bathing resort to include children's camps and private clubs and associations where a membership fee is charged. Signed: April 17.

H-1144. A bill specifying that the director of health shall name the six members of the advisory council for clinical laboratories. Signed: March 8.

H-1560. A bill increasing the penalties for illegal use or sale of narcotics. Signed: April 17.

S-270 (A). A bill to include frozen desserts under the provisions of the law governing frozen dairy products and providing for licensing and regulation of manufacturers and distributors of frozen desserts and ice cream by the director of health. Signed: April 19.

SCHOOL HEALTH. H-1119. An act deleting from the law a requirement that the state director of health provide equipment for the examination of hearing, speech and vision of schoolchildren. Signed: April 17.

SOCIAL WELFARE. H-1073. An amendment providing for a nine-member Advisory Commission to the Division of Public Assistance. Signed: March 13.

H-1074. An amendment for a seven-member Advisory Council to the Department of Social Welfare to be named by the governor for five-year terms. Signed: March 13.

H-1327. An act providing that issuance and renewal of licenses by the director of social welfare to day nurseries and children's boarding homes shall be for one instead of two years, and deleting the requirement that the facilities care for at least two children to qualify. Signed: April 17.

SOCIAL WELFARE. H-1331. An act authorizing the issue of bonds and notes for new medical and preschool facilities at the P. I. O'Rourke Children's Center, rehabilitation of medical and correctional facilities of the department of social welfare, and improvement of the institutional facilities thereof. Signed: April 2.

S-57. An act changing the name of the Hospital for Mental Diseases to the Institute for Mental Health, the State Infirmary as a General Hospital, and together as the Rhode Island Medical Center. Signed: February 7.

H-1439. An act establishing a nine-member Governor's Advisory Council to the Rhode Island Medical Center. Signed: April 17.

TEMPORARY DISABILITY. H-1112. An act increasing the maximum Temporary Disability Insurance to 55% of claimant's average wage, but

concluded on page 294

consider
the convenience
to pregnant
women of
a tablet this size



ENGRAN

Squibb Vitamin-Mineral Prenatal Supplement

FORMULA SUPPLIES 45 MG. OF IRON – AT NO EXTRA COST

The size of a prenatal vitamin-supplement tablet is important—the nausea and gastric distress often associated with pregnancy may make swallowing *anything* a real problem. Hence the small size of the Engran tablet is a great convenience to your pregnant patient, for Engran is actually the *smallest* tablet now available for prenatal vitamin-mineral supplementation. Yet only *one Engran tablet* a day will provide all these vitamins and minerals to help assure a nutritionally perfect pregnancy –

Vitamin A 5,000 U.S.P. units; vitamin D 500 U.S.P. units; thiamine 3 mg.; riboflavin 3 mg.; pyridoxine 2 mg.; vitamin B_{12} 2 mcg.; niacinamide 20 mg.; calcium pantothenate 5 mg.; vitamin C 75 mg.; calcium 100 mg.; iron 45 mg.; iodine 0.15 mg.; copper 1 mg.; magnesium 6 mg.; zinc 1.5 mg.; manganese 1 mg.

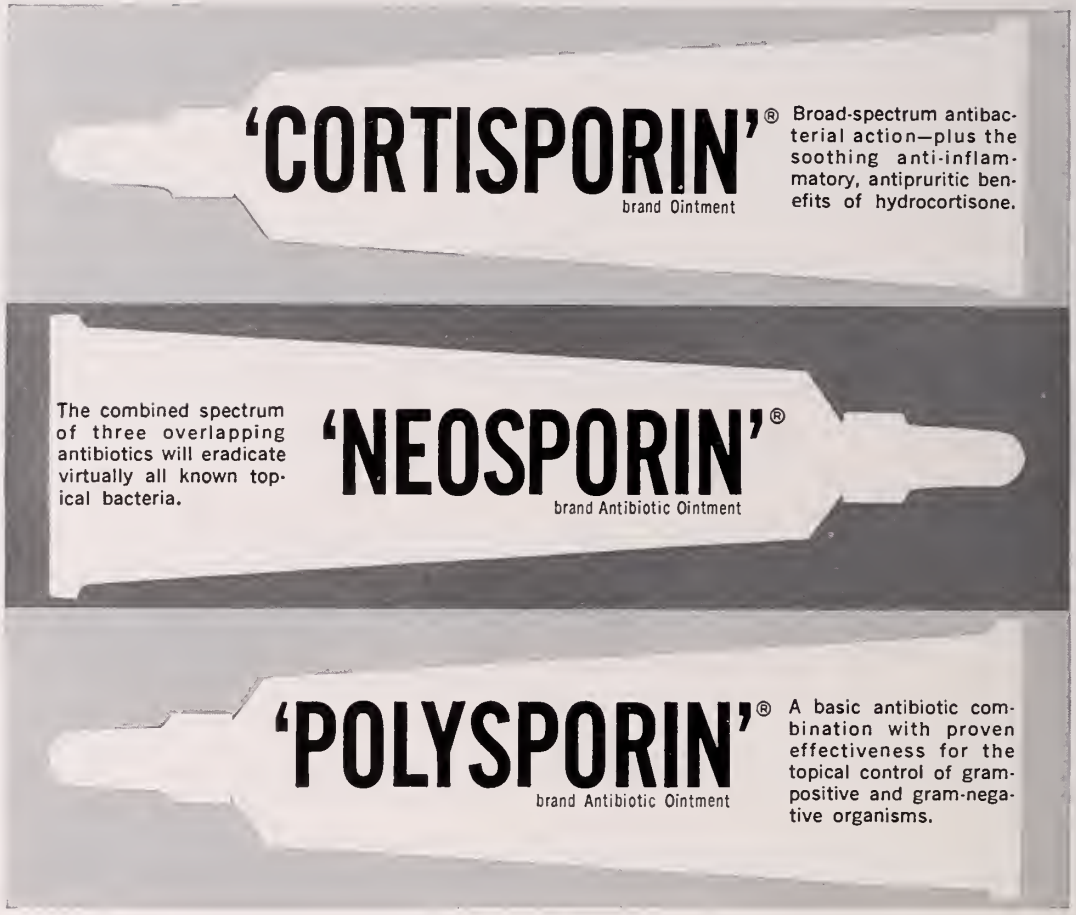
For full information see your Squibb Product Reference or Product Brief.

SQUIBB *Squibb Quality—the Priceless Ingredient*

SQUIBB DIVISION Olin

Engran® is a Squibb trademark

'B. W. & Co.' 'Sporin' Ointments rarely sensitize . . . give decisive bactericidal action for most every topical indication



Contents per Gm.	'Polysporin'®	'Neosporin'®	'Cortisporin'®
'Aerosporin'® brand Polymyxin B Sulfate	10,000 Units	5,000 Units	5,000 Units
Zinc Bacitracin	500 Units	400 Units	400 Units
Neomycin Sulfate	—	5 mg.	5 mg.
Hydrocortisone	—	—	10 mg.
Supplied:	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of ½ oz. and ⅛ oz. (with ophthalmic tip)

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York



THERAPEUTIC NEED: Suppression of the bacteriuria.

ANTIBIOTIC: DECLOMYCIN®

Demethylchlortetracycline Lederle

because it provides effective antibacterial activity in the urinary tract.

quest complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

EDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York Lederle

BOOK REVIEWS

RELIEF OF SYMPTOMS by Walter Modell, M.D. Second edition. The C. V. Mosby Company, St. Louis, 1961. $11.50

"Let's hurry, hurry, use the new drug before it stops curing." This bit of irony, attributed to an olden sage, is obviously cherished by the author. But it pertains in concentrated essence today and partially explains the production of a second edition in six years. The author has eminent qualifications for the task as he is director of clinical pharmacology at Cornell University and a member of the General Committee on Revision of the United States Pharmacopoeia XVII. He states that his goal was to produce a guide to relieving distress which would be a counterbalance to the advertising pages of our medical journals. He has accomplished this Herculean task within the realms of what is possible, but in doing so he must have felt as though he were jouncing with windmills while racing on a treadmill.

The author feels strongly that "what the symptom causes can be as important as what causes the symptom." He feels fortified in this stand by the works of Selye, and other modern investigators, which indicate that distress causes stress and its variegated syndromes. The conclusion follows that, when well controlled, the treatment of symptoms is good practice. And in evolving these controls it is found to be a boon in the everlasting race into the future and the use of drugs which are not yet obtainable or even discovered.

All will agree that a stiff-necked righteousness hewing to the law of diagnosing first and then using a specific remedy, if possible, while petulantly shoving the symptoms aside in a zone of neglect, has nurtured the rise of cultists and charlatans. It is also true that overuse and misuse of specific cures has given rise to what Moser calls "diseases of medical progress." The author is unduly solicitous and sensitive in fortifying what must seem like self-evident truths, to many, with seventy-two pages of rationalization and contention. That there may be some merit in this thought is suggested by the fact that the author after some introspection and heeding of critiques subsequent to the first edition saw fit substantially to contract these initial chapters devoted to argument.

Having waded through the morass of cerebration to the clarity of science a revealing and valuable body of fact is evident. The author has hit upon a happy and lean vehicle to speed along in developing his thesis in that it is centered on the analysis and treatment of twenty-seven symptoms beginning with pain and ending with jaundice. It is first pointed out that it is not always easy to decide what is a symptom. A nice example of this is the account by Margaret Mead of the two racially identical groups, the Itamul and the Manus, living near New Guinea. The Itamul have diarrhea and the Manus, constipation. By their own standards each is normal and the other symptomatic. This type of incongruity is further expanded by the author at the very beginning of chapter eight on *Headache* when he innocently states that there are two kinds of "headache," those which patients treat themselves and those which patients bring to their physicians."

Each symptom is fullsomely treated in its own chapter, and the up-to-date pertinent lists of all the classifications of proprietary drugs are as definitive as possible and will be found to be a time saving and clear aid.

The list and analysis of sedatives and tranquilizers, particularly, is timely and meaty. As the result of much needed research in this field it is pointed out that the undebatable excellent results in psychiatry with large doses of tranquilizers does not prove the efficacy of the doses commonly used in general medical practice.

In the chapter dealing with the symptom of overeating it is pointed out that three per cent of overweight is due to organic disease. The minute place for drugs in the treatment of overeating is indicated by the fact that the "lift" from amphetamines is merely a substitute for the psychic "lift" obtained from overeating.

After all the symptoms are dealt with, the author pays a tribute to the weight of the problem by adding a last chapter on *Cortisone and the masking of symptoms*. This is dedicated to the idea of how not to provide relief of symptoms. It is admitted that although some of the adrenal hormones are the symptom relievers par excellence, it achieves alleviation by a mechanism which indiscriminately suppresses adaptive phenomena. It tends to mask the course of the basic disease in such a way that the

concluded on page 294



THE AMERICAN ASSOCIATION
F MEDICAL MILK COMMISSIONS
JPERVISES THE PRODUCTION OF

Certified MILK

1. CLEANER. Lowest bacteria-count. Milk checked before each milking. All utensils, bottles, and equipment sterilized before use.

2. BETTER-PROTECTED. Strictest medical supervision of herds and employees. Frequent examinations and laboratory-control AT THE FARM are required.

3. AUTOMATIC MILKING. Cows are milked automatically by electric machine. Milk is bottled without exposure to air or human touch.

4. BOTTLE CLOSURES. Must be of the highest quality to provide complete protection for the milk and bear approval of The American Association of Medical Milk Commissions.

5. MORE NUTRITIOUS. Cows scientifically fed balanced ration. Nutrition control from soil to delivery of milk. Same diet all year.

6. LONGER-LASTING, BETTER-TASTING. Diet control, special handling, and shortest time of delivery from cow to consumer assure fine fresh flavor that lasts for weeks.

7. THE DOCTOR'S MILK. Produced, processed, bottled on farms supervised by Medical Milk Commissions. Each bottle bears the seal of the A.A.M.M.C. and names of the supervising Commission and producing farm.

MILK COMMISSION OF PROVIDENCE MEDICAL ASSOCIATION

HILLSIDE FARMS, INC., 1308 Phenix Ave., Cranston, WI 2-3400
Produced at Hillside Farm, Cranston, R. I.

H. P. HOOD & SONS, 135 Harris Ave., Providence, DE 1-3024
Produced at Hood Certified Farm, Beverly, Mass.

WHITING MILK CO., 40 Tockwotton St., Providence, GA 1-5363
Produced at Hampshire Hills Farm, Wilton, N. H.

BOOK REVIEWS

concluded from page 292

physician is left completely in the dark on what is going on and conceals the development of complications. We are left to ponder the thought that an attribute of these hormones, euphoria, leads to habituation, which some adventurers and poets already know. HARRY HECKER, M.D.

MODERN CONCEPTS OF HOSPITAL ADMINISTRATION. Edited by Joseph Karlton Owen, B.S., M.S., PH.D. With the Coordinative Assistance of Robert K. Eisleben, B.A., M.A. W. B. Saunders Company, Phil., 1962. $16.00

This is probably the most comprehensive publication dealing with the many complex phases of hospitals that has ever been placed before the public in one volume. The chapters are well written in plain understandable language which will appeal to everyone.

All persons involved in any way with a hospital such as members of the governing body, administrators, auxiliary group, prospective hospital benefactors, visiting staff, hospital personnel, patients, visitors, business contacts, etc. will find something of value in this book.

It would be difficult to select any particular subject of more than ordinary interest. There are so many important areas covered. However, the observation of the difference in professional nursing care given to the patient by the European and American nurse, which to some may have seemed inconsequential, made an impression on me.

On the whole I consider this book of considerable value. My only criticism, if any, is the possibility of too much material to be absorbed in the average reader's limited time. HILARY J. CONNOR, M.D.

MEDICAL PHARMACOLOGY. Principles and Concepts by Andres Goth, M.D. The C. V. Mosby Co., St. Louis, 1961. $11.00

It was refreshing to read this short textbook of pharmacology that is nearly current with the medical literature. All the newer and useful drugs are summarized, and specific critical comments are made. For instance, the author does not see any value in the use of the short-acting synthetic sedatives when the time-proven barbiturates are available in a variety of range of action and duration of effect. As another example, he analyzes the currently available methods of therapy of barbiturate intoxication. Again, the evaluation is critical and current.

This book is written with the physician in mind, and the understanding of its contents would greatly enhance medical therapy and the critical evaluation and usage of new drugs.

ANTHONY CAPUTI, M.D.

For Sale!

Well established 8 years, general practice in lovely South County. Near 87 bed South County Hospital.

Fully equipped office

Reason for selling — returning to specialty training.

PLEASE REPLY TO
DAVID C. DEWEES, M.D.
at ST 3-5707

HEALTH AND WELFARE LEGISLATION

concluded from page 288

limited to 50% of average wage of covered workers for preceding year. Also increases minimum from $10 to $12 weekly. Signed: April 9.

WORKMEN'S COMPENSATION. H-1029 (A). An act increasing additional compensation for specific injuries from $24 to a $27 maximum, and from $12 to a $14 minimum, and adding facial disfigurement which diminishes earnings to the list of specific injuries. Signed: April 23.

Legislation Vetoed

CHIROPRACTIC. S-46. An amendment to the Basic Science Law that would exempt chiropractic applicants from the requirement of one year in an academic college as a preprofessional education requirement.

S-87. An amendment that would have made chiropractic physicians "participating physicians" in the Rhode Island Medical Society Physicians Service insurance plan.

BLOCK ISLAND. S-356. An appropriation of $5,000 to refurbish a residence on Block Island for use by a resident physician.



"Feel any different now, Mr. S.?" "I thought nothing was happening, Doctor... but then my wife saw a change ...said I wasn't fighting all the time. People at the office seemed easier to work with." "How about drowsiness?" "No, not when I need to stay awake."

In the treatment of mild to moderate tension and anxiety, the normalizing effect of TREPIDONE leaves the patient emotionally stable, mentally alert. Adult dose: One 400 mg. tablet, four times daily. Supplied: Half-scored tablets, 400 mg., bottle of 50.

this could be your "anxiety patient" on

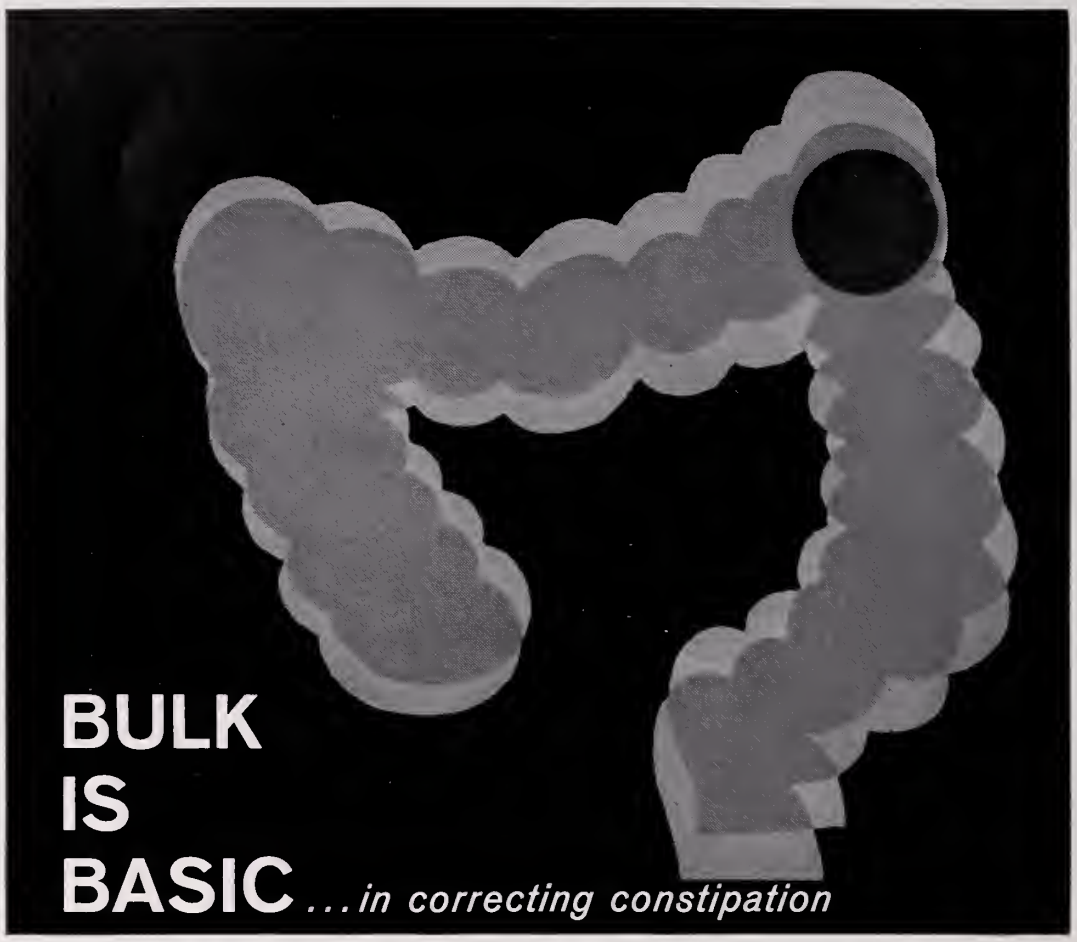
TREPIDONE®

MEPHENOXALONE LEDERLE

Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle



METAMUCIL®

BRAND OF PSYLLIUM HYDROPHILIC MUCILLOID

STRENGTHENS THE COLONIC REFLEX

"The natural stimulus to peristalsis[1]... is the distension of the intestinal wall...."

The effectiveness of Metamucil in correcting constipation is a direct result of its physiologic action.

The stimulus which initiates the defecatory reflex is the fecal mass in the lower sigmoid colon and rectum. Metamucil provides that mass as a bland, nonirritating, easily compressed bulk, similar in consistency to the normal protective mucus of the colon. Taken regularly, Metamucil tends to correct the insensitive reflex of a bowel abused by laxatives and to restore the natural responsiveness to the urge to stool.

Metamucil is available as Metamucil powder in 4, 8 and 16-oz. containers and as lemon-flavored Instant Mix Metamucil in cartons of 16 and 30 single-dose packets.

1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice, ed. 6, Baltimore, The Williams & Wilkins Company, 1955, p. 578.

G. D. SEARLE & CO.
CHICAGO 80, ILLINOIS

Research in the Service of Medicine

The RHODE ISLAND MEDICAL JOURNAL

VOL. XLV JUNE, 1962 NO. 6

THE DOCTOR'S IMAGE — PAST, PRESENT, AND FUTURE*

SAMUEL ADELSON, M.D.

The Author. *Samuel Adelson, M.D., of Newport, Rhode Island, President, 1961-62, the Rhode Island Medical Society.*

SEVERAL DECADES AGO many homes were decorated with a picture calendar depicting "The Doctor" by Sir Luke Fildes. A little child is very ill, the bearded kind-faced doctor is sitting by her, watching her with a troubled look. The parents are seen in the background in an attitude of fear and sadness. The scene is very dramatic. Life or death is in the hands of God and the doctor. Faith in God and doctor helps the parents through their ordeal. Whatever the outcome, the doctor is still their trusted friend. They consult him on all matters — not only health. They seek his advice concerning business ventures, children's education, marriage, and all other intimate matters.

Such was the image of the family physician. He did not have to worry about a bad press, possible law suit, or third parties involved in medical care. The patient came to him when ill; he gave his best efforts, administered medicine empirically, and gave large doses of encouragement and confidence.

The image of the doctor in this day has changed but how has the doctor changed? Is the change for better or for worse? In the case of the little girl in the calendar picture who probably had pneumonia, what can the doctor do for her? His medication is practically useless, and the mortality in pneumonia may be as high as 30 per cent. The doctor of today would treat this patient in the hospital. X-rays, blood test, sputum examinations, cultures, and sensitivity tests are all available. Oxygen and specific antibiotics are available. Instead of a prolonged febrile debilitating disease, frequently the patient is practically cured in 24 hours. Neither does the doctor of today lack the kindness and concern of his predecessor. Today's doctor is steeped in scientific medicine. The drugs that he uses and the surgical procedures that he performs were unknown and not even dreamed of by the doctors of 40 years ago, 30 years ago, or even 20 years ago. He has put in many more years of study and preparation for his practice. He is not less sympathetic, but is accused of being impersonal and arrogant. He is blamed because he does not wish to make unnecessary house calls, but he knows that the patient can derive greater benefit from an office visit or an examination at a hospital. He is accused of leaving his practice too often, but he attends many more scientific meetings and refresher courses to better enable him to treat his patients. He is blamed for the high cost of medical care, but the doctors' fees have increased much less than the cost of drugs, hospital services, and nursing care. Patients get much more for their medical fee now than ever before in terms of preventive medicine, lessened morbidity and mortality, increased longevity, decreased periods of hospitalization and convalescence, and fewer days out of work.

The doctors' image now is apparently seen through a mirror which causes a very ugly distortion. The fact is that almost every individual believes in his own doctor. He considers his doctor able, competent, honest, sympathetic. He entrusts his health and life and that of his family to the hands of his doctor and feels a sense of security. He has chosen his doctor of his own free will and discusses his medical problems with him easily and without restraint. There is a complete understanding which is mutually satisfactory and beneficial. The diagnosis is explained to the patient and also how the diagnosis is reached. The type of therapy, medical or surgical, is carefully and plainly described and all possible eventualities are explained. The patient is enlightened and the doctor does not hide behind scientific terminology and a façade of superiority. Yes, the patient likes his doctor, trusts and believes him. But the same patient is made to believe that a majority of the doctors are not like that. He is made to believe, by exaggerated newspaper stories and by irresponsible statements from people who represent selfish interests or who have

concluded on next page

*Presidential address delivered at the Sesquicentennial Meeting of the Rhode Island Medical Society on May 9, 1962, at the Marvel Gymnasium, Brown University, Providence, Rhode Island.

political ambitions, that doctors are making too much money. That they do not deserve the fees they ask. That they abuse Physicians Service plans and other insurance companies. Unfortunately, people who make such statements are not required to substantiate their accusations by proof, and the accused is not given the opportunity to disprove these wild accusations. The newspapers are immune as long as they omit names and only print what is told to them, giving their source of misinformation. This sells newspapers and makes money. They are on firm ground legally. But, from the moral aspect, are they serving the public interest by being accessory to the act of blackening the reputation of the members of a noble profession without proof of wrong-doing? Are they carrying out the proper functions of the fourth estate? I commend the doctors of Rhode Island for maintaining their dignity under fire and for refusing to enter a name-calling contest. They feel morally strong in the knowledge that the attacks upon them are untrue and unjustified. A thousand doctors should not be subjected to abuse and suspicion for the faults of a very few.

Regarding these few doctors who are proven guilty of unethical conduct, their actions cannot be condoned. Dishonesty in our profession is abhorrent and must be wiped out. Let us take an example from a universally accepted principle in treating disease. A malignant tumor must be destroyed to save the rest of the body. In a similar manner unscrupulous, dishonest doctors must be removed not only to remove suspicion from all doctors, but what is more important, to prevent them from preying on the unsuspecting public.

The American Medical Association is advocating closer contact between medical societies and state directors of professional regulation. Following this recommendation a conference was recently held by Doctor Francis Sargent, chairman of our grievance committee, and myself, with Mr. Thomas Casey, chief of the division of professional regulation, and Doctor Joseph Cannon, state director of health. It was agreed that if we find a doctor guilty of gross unprofessional conduct, in addition to the penalty imposed by the Medical Society, the matter will also be referred to the proper state agency for whatever further action is warranted. We must clean our own house of any wrongdoers, but this must be done in an orderly fashion. Charges against a doctor must be proven by evidence that will hold, and the accused must be given every opportunity to exonerate himself. There is no room in the Rhode Island Medical Society for those who abuse the public, either privately or through insurance companies, employees' compensation, or in any other way.

I believe that the distorted reflection is gradually, but definitely, being straightened out. The image of the doctor is now beginning to appear as a reasonable likeness, without wings or halo, but also without horns or cloven hoof. The campaign to lower the prestige of the individual physician and to defame the American Medical Association and state and local medical societies has sunk to new lows of gutter sniping. All faults or imaginary faults of the profession were grossly exaggerated and all great achievements were minimized or ignored. This was part of an organized plan by those who desire a total welfare state and look to the eventual socialization of medicine as well as other services. Public funds are used to further this campaign. The over-65-years-of-age men and women are transported to meeting places and told when to applaud. They are promised pie in the sky: total paternalistic care of all their needs at no cost to them. Who will pay the bill? I believe that it is immoral, improper and illegal to use public funds to further this political movement.

It appears to me that this mud-slinging has backfired. Our detractors are now seen in their true light, and their real purposes are being understood more and more. You can't fool all of the people all of the time— not in America. When all the facts will be exposed to the pure light of reason and understanding, when the clouds of distrust and calumny will be dissipated, the doctor will not be found wanting; and our profession will again take its place in the minds of men of good will as a noble profession whose members are dedicated for the public good.

It is worth noting that among all industries, the pharmaceutical industry employs the highest ratio of scientifically-trained men to other employees — 4.5 per 1,000, as against 1.27 for the chemical industry, 0.62 for petroleum, and 0.43 for the electrical industry. As a measure of their work in 1961 alone, the 16,000 scientists of the pharmaceutical industry published 5,000 scientific papers on their studies. A 1959 report in *Science* magazine by J. C. Fisher, of General Electric, broke down this publishing activity statistically in an interesting way. He calculated that each paper cost its company $26,000. Or to put it another way, it was the cost of a year's work for 1.37 scientists on the staff.

—*The Science and Economics of Industrial Research:* John E. McKeen, Chairman of the Board and President, Chas. Pfizer & Co.

Patronize Journal Advertisers

HUMAN DESTINY'S NEW DIMENSIONS*

HONORABLE JOHN O. PASTORE

The Author. *Honorable John O. Pastore, United States Senator from the State of Rhode Island.*

THE MONTH OF MAY is extremely historic to us — we, the people of Rhode Island. At almost the beginning of the month we have our special Independence Day, and almost at the end of the month we have our hallowed Memorial Day.

May, then, to us is a most appropriate month to mark the century and a half of our organized medical history. The recorded service of the Rhode Island Medical Society is a heritage second to none in our state's treasure of happiness and health.

The achievements of medicine in all these years make a splendid picture in which you can all take pride. With us there is a special intimate affection as our eyes focus on individual members of your profession. They are doctors, friends who have been close to our hearts, our homes, our hopes, our fears, our sorrows, and our joys.

In a tribute to one especially dedicated, one especially deserving, your guest of honor, Doctor Sabin, we join with all our hearts.

Life, by its very nature, shrinks from illness and from pain. We have a respect approaching reverence for those men and women who dedicate *their* lives to making *our* lives more livable.

We laymen are constantly thrilled by the immensity of medicine, the absolute devotion of its disciples, its endless research, its modern miracles, and its history of all the centuries. The Hippocratic Oath is evidence not only of the ethics of medicine but also of its antiquity. We celebrate 150 years. Medicine reaches back with man over 150 million years. It probably reaches back to the very beginning of the river of life, some three billion years ago. In the measure of three billion years, 150 years might seem infinitesimal. If so, then a quarter of a century would shrink to the vanishing point. But it does not seem so to me.

For the quarter of a century on which I am looking back, are the years of my public life. And in that quarter of a century I feel that you and I have lived in an era without equal in all the history of mankind. It was my privilege, as Governor of the State of Rhode Island, to be fairly close to the giant strides that medical care was making in our state in the post-war forties. The associations of those days are both warm memories and prized possessions of today.

In Washington, through my duties in the Senate, it has been my privilege to come in contact with some of the outstanding figures of science and medicine. They are the men who are helping to shape the history of our times. And in the field of atomic energy, these are the men who are helping to determine the dimensions of human destiny. Some of them will be meeting with you next month in Chicago. Some two hundred scientists will join with more than 15,000 of you physicians at your convention which has for its theme, *Medicine in the Atomic Age*. Jointly with the Atomic Energy Commission you will have a forum on *Nuclear Medicine — Present Achievements and Future Promise*.

I have mentioned the antiquity of medicine. And so, by contrast, twenty years ago atomic energy was unknown in our lives. Twenty years ago nobody would have guessed that, today, nuclear energy would be the Number One factor in balancing, or unbalancing, the world. Atomic energy came to us with a devastating suddenness. It came so suddenly and so violently that our minds are more likely to dwell on its violence than on its virtues.

But, to the minds of the thoughtful, the virtues are so many, the nuclear promises of peace are so great, that we find it hard to conceive how any nation in its right mind will not join with us in choosing between the evil and the good of this natural power.

In this free forum, we can venture to talk about evil and good. We would be free to discuss violence and virtue, and what we shall do with our atomic power. In the free air of a democracy, we dare to talk about standards of human decency, and dignity, and liberty. We can talk about these attributes of freedom because we possess them. They are ours, and no tyrant can seal our lips in silence. We can talk about atomic power because we possess it, and the understanding know that the potential enemy respects us for that and for that alone.

continued on next page

*Convocation address delivered at the Sesquicentennial Meeting of the Rhode Island Medical Society, at the Marvel Gymnasium, Brown University, Providence, Rhode Island, on May 8, 1962.

Imagine, in an atomic world, if we of America were the have-nots. Where would be our liberty, our human dignity! Would we be permitted to meet here for *any* reason, much less to express in free terms our appreciation and affection for those whose lives are lived in genuine love of their fellowman?

It is frightening to recall how close to disaster we came. It is well to recall that it was hatred of neighbor and racial persecution that tore atomic discovery away from the laboratories of the heartless Hitler. By 1933 Hitler had confiscated the property of Albert Einstein. The world's most famous physicist was also the world's most famous Jew. Nazi arrogance derided Einstein's learning. Science had to be based on race and not on reason.

By the winter of 1938 Hitler had succeeded in driving beyond his frontiers most of Europe's most experienced nuclear scientists. They were among the select few whose minds, alone among the world's millions, would be able to understand and develop the discoveries about to be made. It was the refugee, it was the procession of the persecuted, from Einstein to Fermi, who brought us the gifts of their minds and the alliance of their hearts. It was the teamwork of some six nations that finally revealed the secret of the atom for the benefit of the free world. It happened here in the remoteness of America. We had limitless resources, and we had the resolution of a President who gambled the billions for the birth of the bomb.

So we are free to meet, with fear of no one, and, more importantly, with hatred for no one. We readily understand that all is not pleasant in the picture, and in the light of our times we must match the peaceful promise of the atom with the common sense of basic security. Confidence in our defenses gives us confidence in our destiny. And with that confidence, in good conscience we invite the world to share in the opportunity for plenty and for peace.

We believe that we stand on the threshold of a time of fabulous promise for all mankind. I have just been turning the pages of the latest report of our Atomic Energy Commission. More than 300 pages summarize our progress on atoms for peace. Almost half of the volume is given to its alliance with medical research and the general sciences of life. I am sure that your June Convention will add another illustrious page to this report.

Atomic history is being made all around us. Turn on your electricity, and part of it comes from atomic power. Today the Yankee Atomic Plant sends its power into the grid for all New England. Tomorrow we will see such a reactor transform the land of the impoverished into a land of prosperity. Today we launch a nuclear submarine on its errand of security. Tomorrow it will be sounding the depths of the oceans for all their wealth and the tides and the depths of the sea will yield their unlimited power. Today the program for a communications satellite is in the advanced stage. Its earth station rises in Maine and some tomorrow the satellite will orbit in rhythm with the rotation of the earth. Tomorrow one of your skillful operations will be caught by that satellite 20,000 miles in space and televised to the remotest ends of the earth, so that doctors may learn and so that humans may live.

We speak of these marvels, these miracles, as though they were inanimate things. Behind each, behind, beneath and above, is the human equation — it is the evolution in God's good time of man's brain and the development of man's conscience. Behind each achievement is the determined will, the devoted sacrifice, and the dedicated intelligence of the individual. These are men who lean on the tradition of all that has gone before them, and they blend it with their talents for the betterment of humankind.

I have spoken of the report of the Atomic Energy Commission. Its goals and gains are tremendous. But to me the golden pages of that report are the page after page of the names of scientists whose labors and laboratories are enlisted in the common cause. There you will find names from Brown University, from Providence College, and the University of Rhode Island, ranked with all the brains of all the schools and all the scholarship of America. At this moment, in some laboratory, a doctor, a scientist, toils away to unlock some secret that tomorrow may save your life or mine. Some student will be burning the midnight oil as the call to medicine or science intrigues his heart and invites his ambitious soul.

Tomorrow, and Heaven knows how much tomorrow will need him, he will be by your side in the never ending quest to perfect this human world stumbling along amid all its imperfections. This is the wealth of America, indeed, the wealth of the free world, its manpower and its mindpower. This is the measure of the meaning of liberty and opportunity. This is the measure of the progress of man, rising out of the struggles of the centuries to the light of intelligence, conscience and responsibility.

We have much to make us grateful. Life is richer as we know life longer. But the billions of years challenge our comprehension. So we are happier in the compass of our own experience. Again, life is deeper. We have greater knowledge of some of life's causes, life's crises, life's catastrophes, and we have devoted men concerned with their cures. And, again, life is higher. It is more rewarding and more demanding. Never quite sure of our command of earth, we would penetrate into the realms of space where man has never gone before.

Man is still earth bound. We walk as humans in the valley of existence. The valley is watered by the

concluded on page 304

MEDICAL EDUCATION AND BROWN UNIVERSITY*

GLIDDEN BROOKS, M.D.

The Author. *Glidden Brooks, M.D., of Providence, Rhode Island. Director, Institute for Health Sciences, Brown University,*

ONE HUNDRED AND FIFTY YEARS ago, when the Rhode Island Medical Society was chartered, there were students pursuing their studies in the infant medical school established a year before on the campus at Brown University. These were days of bright promise for medicine in Rhode Island. The chronicle of the Medical Society records the fulfillment of these expectations in increasing measure over the span of a century and a half. What is the story of medical education at Brown University?

The details of Brown's early medical program have been admirably recorded by Seebert Goldowsky, the distinguished present editor of the Journal of this society. It will, therefore, suffice here to point out only a few significant features. During its brief sixteen-year activity, Brown's medical school, the third in New England, was not unsuccessful. Eighty-seven degrees of Doctor of Medicine were awarded, and many of the graduates became physicians of accomplishment and note. The faculty, though small, was most certainly distinguished for that era, and, in fact, included some of the founders of this Society.

On March 15, 1827, upon the recommendation of President Francis Wayland, the Brown Corporation passed a resolution requiring "that all its officers be actual residents within the walls of the Colleges." Although not primarily designed to do so, this ruling had the effect of abolishing medical education on the Brown Campus. None of the professors of medical subjects (who were also leading practitioners of medicine) was in a position to conform to this stipulation. If one permits some small liberty with historical fact, the foundering of our craft upon the shoals of the need for full-time teaching of medicine may be construed as prophetic by a hundred years of one of the recent great issues in modern medical education. However, the most significant thing about the discontinuance of the Brown Medical School was that the University, at least in the opinion of President Wayland and the Corporation, was not then ready financially and otherwise to fulfill the promise of excellence which such a beginning deserved. President Wayland indeed assured Doctor Usher Parsons in a formal letter that, whenever the medical school was resumed, its standards would be as high as any in the country. This early concern for quality has continued to be the paramount qualification in any consideration of medical affairs on the part of Brown.

On June 3, 1961, upon the recommendation of President Barnaby Keeney, the Brown Corporation voted to proceed with the planning and development of a new program of medical education. This addition to the life sciences is therefore, in a very real sense, not new, but a resumption of the program which President Wayland, in that same letter to Doctor Usher Parsons of the medical faculty, indicated had not been abolished, but merely suspended.

The interim period has been marked by numerous personal associations and co-operative scientific efforts between Brown faculty and members of the Rhode Island Medical Society. Rather than to attempt to chronicle these here, it seems appropriate to look ahead and to report to this body the progress of events which begin our next century of mutual relationship.

The decision by President Keeney and the present Corporation was based on a study by a committee of Brown faculty, administration, and trustees assisted by a panel of consultants from the field of medical education. This study committee recommended that it was immediately feasible for Brown to develop a program which combines the usual college premedical education with the basic medical sciences currently offered in the initial two years of medical school. At the same time the opportunity could be provided for doctoral and post-doctoral graduate studies in the medical sciences.

It should be noted that the commitment by the Brown Corporation was specifically limited to this program, and it was further stated that consideration of offering the clinical years necessary for the awarding of the M.D. degree should be deferred until the successful operation of the basic science

continued on next page

*Presented at the Sesquicentennial Meeting of the Rhode Island Medical Society on May 8, 1962, at the Marvel Gymnasium, Brown University, Providence, Rhode Island.

program was assured. It is apparent that the latter decision is viewed with some impatience and regret by those of us who are eager for a complete medical school program. Yet, if one considers that careful and orderly and time-consuming development is essential because of the complexity of a medical school and its financial and human implications, it must be recognized that the decision is a wise one.

Now, after a year of active planning, a curriculum has been developed and approved by the Brown faculty, and awaits final action next month by the Board of Fellows, which has ultimate jurisdiction in all such University matters. The proposed curriculum begins with the student's admission to Brown as a freshman and embraces six years of study which will bring him to a level at which he will qualify for admission to a regular four-year medical school as a third-year student for the completion of the clinical years of study. He will receive a degree of Master of Medical Science from Brown at the completion of the six-year program.

All of the subjects usually offered in a four-year premedical program and in the two basic science years of medical school are included. However, the customary break at the end of four years is eliminated, and medical subjects are encountered somewhat earlier in the college career, and nonmedical studies are pursued in the final as well as the earlier years. For this reason, the program cannot be regarded simply as a "two-year medical school."

A primary aim is to offer a thorough scientific preparation prior to entering the intensive study of clinical medicine. This is accomplished by providing a comprehensive grounding in the fundamental sciences of chemistry, physics, and mathematics followed by studies in biology, psychology, and sociology which lead to and are integrated with the basic medical sciences. This scientific experience is completed by advanced study in a science of the student's choice. This includes the submission of a thesis reporting the conduct of independent study and research.

Medicine is far more than the simple application of scientific knowledge to human health and disease. The physician must be a man who has acquired deep understanding of the significance of human life in the society in which he lives. He must be personally sensitive to the inmost thoughts and emotions of his patients and, at the same time, fully aware of the significance of his profession to the lives of those whom he serves and to himself. For this reason, the program provides for ample exposure to the humanities and arts in the early college years and requires that each student avail himself of the opportunity for an intensive, advanced level experience in the humanities or social studies in the later years of the curriculum after he has achieved a degree of personal and scholarly maturity.

A characteristic of the Brown program which is worthy of note is the decision to integrate the medical studies as thoroughly as possible into the main stream of the University both in the undergraduate colleges and the graduate school. Full advantage will be taken of the long tradition of excellence and the established patterns of teaching on the Brown campus. The medical faculty, rather than being segregated as a separate unit, will join the Brown faculty as members of departments to which their special interests are most closely related, thus preserving the university-college concept which de-emphasizes the traditional barriers between scholarly disciplines. This arrangement is entirely feasible in a program limited to the basic medical sciences, but, of course, would present interesting problems if and when the University chooses to include the clinical years in its curriculum.

Rather than continue with a description of the details of the proposed curriculum, most of which are necessarily tentative at the present time, it seems more appropriate to devote the remainder of this paper to a summary of some of the considerations which brought about the decision of the University to resume medical education, and which have had a bearing on the direction which the program has taken. The major factors which prompted this action on the part of Brown University are these:

Since the conclusion of the last World War, there has been an increasing national concern for the manpower needs of the future. In the case of medicine, there has been a general awakening to the necessity of making provision for a continuing supply of physicians for a growing population. This has led to a number of widely-publicized studies which are currently being used as a basis for proposed national legislation and as a guide for foundations and other philanthropic interests concerned with the health of the nation. Along with this awakened interest has come an increased availability of funds from both private and public sources for the support of medical education and research, together with the clear likelihood that such a trend will continue for some time to come. Medical education, as you all know, is expensive, and a major deterrent to an independent, privately supported university such as Brown entering this field is a financial one. This is both absolute and relative: absolute in terms of any dollars available for new programs, and relative in the sense that, if insufficient funds are expended, either the quality of the medical program will suffer, or the medical program will make serious inroads upon sources of support which are required for a balanced development of the University. Such a situation is intolerable for those of us interested in medical education, since the strength of medical education, especially of a university-oriented pro-

gram such as we propose, is directly dependent upon the strength of the University as a whole. Therefore, very careful scrutiny was made of the current and future financial picture before the Brown Corporation committed itself to this new program.

A significant and, to some, unexpected recommendation arising from the national medical manpower studies was one urging the development of additional two-year schools of medicine. This was based on the observation that it would be extremely difficult and expensive for existing schools of medicine to enlarge in any great measure the size of their present classes in the basic medical sciences, but that the availability of clinical facilities for teaching is such that the enlargement of the classes in the clinical years of medicine is relatively easy and considerably less expensive. In terms of answering this need, it is, of course, obvious that the six-year program contemplated at Brown will have the same effect in numbers as if we confined our efforts to a two-year school of medicine. A less publicized manpower concern which looms large in the challenge which Brown has accepted is the need for assurance of quality for medicine of the future. This must take the form of a supply of highly educated, scientific physicians. An excessive concern for sheer numbers of physicians for the future can, and quite likely will, produce forces which tend toward compromise with mediocrity, and which in time may even hasten the day when American medicine will contain two classes of physicians similar to those which obtain in Soviet society today. It is imperative, therefore, that those schools which by fortunate circumstance are in a position to place an overriding emphasis on quality and strength of preparation should do so.

Another factor which led to Brown's decision was the high state of development which the physical and biological sciences fundamental to medicine had reached upon this campus. For example, the growth of the Biology Department in the last decade has tended strongly toward emphasis upon fundamental and mammalian biology. The interests of the members of that Department are reflected in the nature of their research programs which are, for the most part, supported by grants from the National Institutes of Health. Similar strengths and interests are to be found in the Departments of Psychology and Sociology, thus making it easier to erase the traditional gap between the so-called premedical and the medical sciences.

Many of the considerations which have influenced the direction which the Brown program has taken stem from changes which have been going on in the very nature of medicine itself. The most important of these is the vast increase in both breadth and depth which has taken place in medicine relative to science. Each of the traditional medical sciences has shown a many fold increase in content and precision. Furthermore, the distinction between a fundamental science and a "medical science" has tended to become hazier and of less importance. In addition, whole new sciences have emerged following upon revolutionary scientific discoveries. The advent of nuclear fission and its rapid application to medical research, diagnosis, and treatment is but one example.

This increase in scientific knowledge is reflected in the volume, now at flood tide, of scientific literature. It is no longer possible for the medical educator to approach his students with any idea of "covering the subject." He must content himself with putting in the hands of the student the concepts, the technical tools, and the guidance which permits the student to learn and organize knowledge for himself, rather than acquire it by rote memory or prefabricated example. This scientific increase has been accompanied also by a growing complexity which is evidenced by the dissolution of traditional boundary lines between scientific disciplines and recombination of parts of previously discrete scientific disciplines into entirely new fields of scholarship. The Brown program, by first providing the student with a firm foundation in the basic sciences and then permitting him to proceed through a logical sequence toward the application of science to medicine, is reflecting the influence of these changes in science.

The requirement in the Brown program that the student have direct and independent experience with the application of the research method to a problem within the science of his choice provides the student with a basic conceptual orientation which he may then apply to other scientific fields and to his comprehension and evaluation of the scientific literature.

These scientific parameters plus the previously mentioned emphasis on understanding the nature of man in society are blended in clinical study and medical practice into what is called, for lack of a more precise designation, the "art" of medicine. It is the aim of the Brown program to provide the student with these essential ingredients in full measure, so that his further medical studies may have a rich source upon which to draw as he develops into the physician of tomorrow. It is our belief that this foundation can best be presented as a continuous experience within the broadening and deepening atmosphere of a free and independent university. We believe that Brown is such a school.

A consideration of very great moment in Brown's decision is to be found in the local climate in which the University exists. Providence and Rhode Island have long enjoyed a conspicuously high level of medical service. This Sesquicentennial observation by the Rhode Island Medical Society bears testi-

concluded on next page

mony to this fact. A community which has harbored such men as Isaac Ray, Charles V. Chapin, Arthur Ruggles, and others, and which follows in their tradition, is an ideal setting for a medical school. The hospitals in the community offer a notably high level of medical care and have long been associated with medical teaching, both at the undergraduate level through affiliations of various kinds with the Boston medical schools and at the graduate level in their growing internship and residency programs. Brown recognizes that if such a situation did not exist in its community, a program of medical education would stand little chance of success. The cooperation and participation of the medical community in the Brown program is anticipated and welcomed, even though this must necessarily be limited in the undergraduate phases of the program to introductory clinical exercises and pathological correlations.

As this teaching program progresses through the early years of its development, increasingly rich opportunities will arise for the joint participation of the University with the medical community in both teaching and research. The latter (research) is inseparable from any part of modern medical education but comes to its greatest fruition in education at the post-doctoral level. Research and teaching opportunities for interns, residents, and fellows in Rhode Island's hospitals, blended with opportunities for research by Brown Ph.D. candidates on clinically related problems, will enrich the scholarly traditions of our medical community which was pioneered by this Rhode Island Medical Society. More important still, it must inevitably result in better and more comprehensive and more scientific health care for Rhode Island citizens in the future —and this has been, since its inception, the fundamental aim and purpose of this Medical Society. Brown University deems it a privilege to join with you in this reinforced mutual endeavor.

HUMAN DESTINY'S NEW DIMENSIONS

concluded from page 300

river of life. The valley is hemmed in by high hills. The hills on the one side are the heights of our own innocence and ignorance. They are the slopes of our imperfections, our perils, our fears, our despair. And yet the hills on the other side are the heights of man's courage, man's experience, the hard-earned wisdom, the sacrifices of good men and good women.

As we grow taller the hills grow smaller. We are lifted by the efforts of great men. Their daring steals the hills of their height. Their intelligence lessens the perils of the farther hills. The dark spots are touched by the bright lights of their discoveries. Brave men teach us that we can aspire to the clouds above the hills, and to the regions above the clouds, to control the very firmament, and good men caution us lest we gain the whole world at the cost of our souls.

The dimensions of human destiny are defined only by the dedication of man. He must care — and, indeed, he must dare. He must be prepared to make the sacrifice, and he must dare the unknown so that tomorrow it shall be the familiar, and the good fortune of mankind.

In this venture we are all together, each according to his talents. Each is to be honored as his labor is honorable. Each is needed, desperately needed, if life, liberty, and the pursuit of happiness continue to have a meaning for us. High or humble, we share in the call to make human destiny in the dimensions of democracy, dignity, and decency. We shall be meek enough to inherit God's earth. But we shall have the power and the purpose to preserve it.

E. P. ANTHONY, INC.
Druggists
WILBUR E. JOHNSTON, Phar. D.
RAYMOND E. JOHNSTON, B.S.
178 ANGELL STREET
PROVIDENCE, R. I.
GAspee 1-2512
Pharmacy License #225

J. E. BRENNAN & COMPANY
Leo C. Clark, Jr., B.S., Reg. Pharm.
Apothecaries
Two Convenient Locations
5 North Union Street Pawtucket, R. I.
140 Central Avenue Seekonk, Mass.
7 Registered Pharmacists
Pharmacy License #226

PATRONIZE JOURNAL ADVERTISERS

TRANSIENT DYSPROTEINEMIA IN INFANTS

JAY ORSON, M.D.

The Author. *Jay Orson, M.D., of Providence, Rhode Island. Associate Pediatrician, Miriam Hospital; Assistant Physician, Department of Pediatrics, Rhode Island Hospital.*

THE TERM "Transient Dysproteinemia in Infants" was first used by Ulstrom, et al., in 1956.[1] They described a syndrome in infants consisting of edema, pallor, and marked irritability due to hypoproteinemia of unknown etiology. Since the initial report, there have been several case reports of this condition in children and infants and rather extensive studies of what appears to be a similar but more serious condition in adults. I will record an additional case and review present concepts of the etiology of this complex but apparently benign syndrome.

Case Report

J.S., a six-month-old white boy, was admitted to the Miriam Hospital* because of generalized edema.

He had been perfectly well until two days prior to admission, when edema of the eyes and extremities was noted, associated with marked irritability.

Past history was possibly significant in that the mother had been exposed to German measles in the second month of her pregnancy. She was given gamma globulin and did not develop any overt disease. The remainder of the pregnancy and delivery were normal. The child had always been a well and very large boy. The mother had been breast feeding him until approximately three weeks prior to admission, at which time she weaned him to whole cow's milk. He was taking about one and one-half quarts of milk a day plus a full, soft diet and vitamin supplement.

Family history is noncontributory.

Examination revealed a large, well-appearing boy. There was marked edema of the eyelids and pitting edema of the extremities and over the spine. The liver edge was 4 cm. below the costal border in the midclavicular line. The remainder of the physical examination was within normal limits.

Laboratory data were as follows: Hemoglobin was 10.8 grams; red blood count 4,500,000; white blood count 11,900 with 24 per cent polymorphonuclear leukocytes; 6 per cent band forms; 64 per cent lymphocytes. Multiple urinalyses were obtained and were all negative; specifically, none contained protein. Cultures of the urine and stool, and examination of the stool for ova and parasites were negative. Blood chemistries were as follows: Sugar 98 mg. per cent; urea nitrogen 22 mg. per cent; total protein 3.4 grams per 100 ml. with 2.3 grams albumin and 1.1 grams globulin. Total cholesterol was 94 mg. per cent; CO_2 20 mEq/liter; sodium 141 mEq; chlorides 110 mEq; phosphorus 5.2 mEq; calcium 4.1 mEq. Total proteins were repeated on the day prior to discharge and were 3.5 grams with 2.4 grams albumin and 1.2 grams globulin. Protein electrophoresis at this time revealed the following values: Albumin 62.8 per cent; alpha 1 globulin 5.8 per cent; alpha 2 14.2 per cent; beta globulin 14.1 per cent; gamma 3.2 per cent. Cephalin flocculation was 1 plus. Transaminase 38 units; thymol turbidity negative. X-ray of the chest and electrocardiogram were within normal limits.

*Providence, Rhode Island

Course in the Hospital

On the second hospital day the patient was placed on a low salt, low protein formula.* He lost two pounds in three days, and all clinical edema disappeared. He was discharged on the fourth hospital day, apparently well. At home he remained on the formula for six weeks and continued well. At that time repeat chemistries were as follows: Total protein 6 grams; 3.9 albumin; 2.09 globulin with 0.3 grams alpha 1; 0.55 grams per cent alpha 2; 0.7 grams per cent beta; 0.43 grams per cent gamma.

He has since remained well and without edema, and now drinks whole cow's milk.

Discussion

The edema in this patient was apparently due to hypoproteinemia. Todd and Sanford[2] state that a total protein of less than 5 grams per cent, and specifically a total albumin of less than 2.5 grams, is associated with clinical edema. Obviously, this figure is subject to a great deal of variation, depending upon age, blood pressure, total salt content, and other factors. The fact that this child's edema cleared rapidly despite no immediate rise in serum proteins would indicate that it was the additional

*SMA-26, Wyeth

concluded on next page

salt in the cow's milk which precipitated clinical edema. Cow's milk contains a total ash content at least twice that of this diluted formula.

In searching for a cause for hypoproteinemia, there were two obvious possibilities: I. The patient was not manufacturing protein at the normal rate; II. He was losing protein excessively.

I. A. It seems unlikely that his hypoproteinemia was on the basis of inadequate intake of protein. If he had not been obtaining sufficient protein from his mother's milk, it is difficult to understand why the edema appeared when it did. For three weeks he had been drinking about one and one-half quarts of cow's milk a day containing approximately 3.5 grams per cent of protein, or a total protein intake of at least 55 grams of protein from his milk alone. This is approximately 5 grams per kilogram. If anything, one is surprised that his urea nitrogen was not higher.

B. A second possible cause of inadequate formation would be hepatic disease. Probably all of the albumin and most of the blood alpha 1, alpha 2, and beta globulin are manufactured in the liver. There was no evidence of hepatic disease in this child. The liver was somewhat enlarged on admission but rapidly returned to normal with disappearance of edema. Liver function studies were all within normal limits and the child never appeared ill. Frequently in liver disease the gamma globulin is increased.

II. There are several possible routes of protein loss. One would be in the urine. However, multiple urines showed no protein, and total cholesterol was normal. Nephrosis or any of its variants was most unlikely. One may consider also, protein loss such as is seen in burns or large areas of skin desquamation. These were not present in our child. He did not have one of the usual types of malabsorption syndromes, such as classic gluten sensitive celiac disease, or any of the diseases which may mimic it, such as intestinal infection with giardia lamblia, ulcerative colitis, regional ileitis, blind loop syndrome, and enteroenteral fistula. When these conditions are associated with hypoproteinemia, there is also evidence of malnutrition. This was not present in our child. He was in the 97 percentile for height and weight. His stools always appeared perfectly normal.

We are then left with a diagnosis of idiopathic hypoproteinemia. This child's history, findings, and course are similar to those originally reported by Ulstrom, et al., including their findings of irritability and edema. Laboratory data were normal with the exception of hypoproteinemia, with or without an apparent iron deficiency anemia. All children recovered spontaneously.

It has been demonstrated with the use of ^{131}I-labeled albumin, in an apparently similar condition in adults, that the basic defect is increased destruction of protein. The labeled albumin appears in the stomach. However, it is broken down to amino-acids by digestive enzymes, and the iodine is then absorbed and excreted into the urine. Thus the patient breaks down and resynthesizes albumin at an increased rate (so-called hypercatabolic hypoproteinemia).[3] It was for this reason that we considered giving our child a low protein milk. If the mechanisms for the metabolism of protein were already functioning at a maximum rate, there seemed little point in adding a heavy, exogenous load of protein. The original studies of Ulstrom and further studies on other patients had shown that over-all nitrogen balance was positive. The situation in adults has been clarified by the use of intravenous ^{131}I-labeled "Polyvinyl Pyrrolidone" (P.V.P.).[3] This is a plasma protein substitute, which is handled by the body similarly to protein. However, it is not broken down by the gastrointestinal tract so that it can be estimated quantitatively in the stools. In a series of adult patients with idiopathic hypoproteinemia studied by Schwartz,[4] they found large amounts of P.V.P. being excreted into the stomach. It is felt, although it has not been conclusively proven, that a similar mechanism exists in children with transient dysproteinemia; that is, that these children are probably excreting large amounts of serum protein into the gastrointestinal tract and then reabsorbing it. Thus, protein in excess quantities is held in the gastrointestinal tract. When the protein is reabsorbed, it is absorbed as aminoacids. Aminoacidemia, as found in several of these children, would certainly be compatible with this theory. Studies of this nature should be undertaken in children with unexplained hypoproteinemia.

Summary and Conclusions

A six-month-old child with hypoproteinemia and edema recovered spontaneously in one month. While he still remained hypoproteinemic, his clinical edema disappeared when he was placed on a low salt, low protein feeding. Further cases of this syndrome should be studied with techniques for measuring excretion of protein into the bowel.

References

[1]Ulstrom, R. A.; Smith, N. J., and Heimlich, E. M.: Transient Dysproteinemia in Infants, A New Syndrome. A.M.A.J.Dis.Child. 92:219, 1956

[2]West, E. S., and Todd, W.R.: Textbook of Biochemistry. 2nd ed. Macmillan Company, New York, 1957

[3]Schwartz, M., and Thomsen, B.: Idiopathic or Hypercatabolic Hypoproteinaemia. Case Examined by ^{131}I-Labeled Albumin. Brit.M.J. 1:14, Jan. 5, 1957

[4]Schwartz, M., and Jarnum, S.: Gastrointestinal Protein Loss in Idiopathic (Hypercatabolic) Hypoproteinaemia. Lancet 1:327, Feb. 14, 1959

GENERAL MEETING OF THE RHODE ISLAND MEDICAL SOCIETY

May 9, 1962

In accordance with the by-laws of the Society, a general meeting of the membership was held during the annual session, at the Marvel Gymnasium of Brown University in Providence, on May 9, 1962. The meeting was called to order by the president, Doctor Samuel Adelson, at 12:30 P.M. Approximately 150 members were in attendance.

Doctor Adelson read the section of the by-laws pertaining to the holding of a general meeting during the annual session, and explaining the purpose of the general meeting.

Report of the Secretary

Doctor Michael DiMaio, secretary, reported as follows:

At its meeting held on April 30, 1962, the House of Delegates of the Rhode Island Medical Society voted to recommend to the membership at the next general meeting as follows:

"That Article X, Section 7, of the by-laws of the Society be amended to change the name of the Committee on Medical Defense and Grievance to hereafter be the Committee on Mediation, and further, that wherever in the said by-laws the title committee on Medical Defense and Grievance appears, it shall be amended to read Committee on Mediation."

A motion was made, seconded and passed that the recommendation as proposed be adopted.

* * *

The secretary reported that at a meeting of the Council of the Rhode Island Medical Society, held on January 15, 1962, it was voted, in accordance with the by-laws, to recommend at the next general meeting of the Society the election to honorary membership in the Society on the occasion of its Sesquicentennial, the following: Mrs. Helen DeJong, librarian of the Society; Hon. John E. Fogarty, U.S. Representative from the 2nd Rhode Island District, and Capt. Joseph L. Yon, MC, USN, Commanding Officer, U.S. Naval Hospital at Newport, Rhode Island.

A motion was made, seconded and unanimously passed that the recommended nominees for honorary membership be elected.

* * *

The secretary reported that at a meeting of the House of Delegates of the Society held on April 30, 1962, the Officers and Standing Committees had been elected.

* * *

Resolution

The president recognized Doctor Charles L. Farrell, president of the Rhode Island Chapter, Academy of General Practice, for the purpose of introducing a resolution. Doctor Farrell read a statement from the Chapter which concluded with the following resolutions:

"*WHEREAS* the Rhode Island Medical Journal, issue of April, 1962, contained an article titled *The Surgical Assistant* which grossly maligned the competent general practitioners of Rhode Island, and

"*WHEREAS* such editorial comment is misleading and tends to create dissension among the profession by emphasizing economic aspects of medical care over patient welfare, and

"*WHEREAS* the Rhode Island Medical Journal should reflect the voice of the whole profession and not the partisan opinions of an editor, now therefore be it

"*RESOLVED* that the statement from the Rhode Island Chapter of the American Academy of General Practice attached herewith be published on the editorial page of the next issue to go to press of said Rhode Island Medical Journal, and further be it

"*RESOLVED* that the editor and/or editors responsible for said editorial be relieved of the duties of editorship and that he or they (as the case may be) be replaced by editors selected by the president of the Rhode Island Medical Society to serve until the next annual meeting of the Society."

* * *

Doctor Adelson noted that the General Meeting may receive and vote on resolutions introduced at any session, but the resolution shall not be binding upon the Society until approved by the House of Delegates.

concluded on page 332

SOCIETY OFFICERS INSTALLED AT SESQUICENTENNIAL MEETING

Doctor Arthur E. Hardy, Warwick surgeon, was installed as the 103d president of the Rhode Island Medical Society at the business session held as part of its Sesquicentennial Meeting at the Marvel Gymnasium of Brown University, on May 9, 1962. He succeeds Doctor Samuel Adelson, of Newport. Doctor Thomas Perry, secretary of the Society from 1952 to 1959, and chairman of the Sesquicentennial Committee this year, was named president-elect to succeed Doctor Hardy next year.

Other officers elected were Doctor Robert R. Baldridge, Providence surgeon and former president of the Providence Medical Association, vice president; Doctor Michael DiMaio, Providence internist, re-elected secretary, and Doctor J. Murray Beardsley, former chief of surgery at Rhode Island Hospital, re-elected treasurer.

A native of Warwick, where he completed his preliminary education at the high school in that city prior to matriculating at Brown, Doctor Hardy is a graduate of Harvard Medical School. After internships at Chapin and Rhode Island hospitals, he established his practice in the Edgewood section of Warwick. He is currently chief of surgery at the Kent County Memorial Hospital.

Successively secretary, vice president and then president of the Kent County Medical Society, Doctor Hardy has served as a councillor and as a delegate to the state Medical Society. He was secretary of the Rhode Island Medical Society, 1959 to 1961, and he has been the Society's alternate delegate to the American Medical Association for the past nine years.

President-elect Westerly Native

Doctor Thomas Perry, Jr., named president-elect, is a native of Westerly. He attended Loomis School, and he was graduated from Harvard University and Harvard Medical School. He served an internship at Rhode Island Hospital and then enlisted with the 48th Evacuation Hospital Unit which saw war service in the China-Burma-India theater of operations. He held the rank of major when the war ended, and he was awarded the CBI Theater ribbon with two battle stars. He then completed a residency in surgery at Rhode Island Hospital prior to establishing a private practice in Providence.

Doctor Perry is presently a surgeon on the Rhode Island Hospital staff, chief of general surgery at Lying-In Hospital, a member of the consulting staff at Westerly and Woonsocket hospitals, and a member of the courtesy staff at Roger Williams General Hospital. He has been active in the work of the Society for many years, serving as its secretary for seven years, and heading the Sesquicentennial Committee this year which staged the successful Exposition of Health Progress at the Cranston Street Armory last month.

Doctor Baldridge Vice President

A native of Pennsylvania, Doctor Baldridge, Providence surgeon named vice president to succeed Doctor Frank I. Matteo, adopted Rhode Island as his home after completing his academic studies at Brown, and his medical studies at Harvard Medical School. He served internships at Rhode Island and Boston City hospitals, and a residency at St. Luke's Hospital in New York before establishing his residence in Providence. During the World War he served as a commander in the Navy with overseas duty in England at the time of the D-Day invasion of the Continent.

In 1956 Doctor Baldridge served as president of the Providence Medical Association. He has also been active in the affairs of the state medical society, serving on many important committees, and as a delegate to the House of Delegates for several years.

Doctor Michael DiMaio, re-elected as secretary, is also secretary of the board of examiners in medicine for the state, and he has been an active participant in medical organization work for many years, having served as secretary of the Providence Medical Association from 1951 to 1959. He is a native of Providence, a graduate of the University of Rhode Island, and of Johns Hopkins Medical School.

Re-elected for his fourth term as treasurer, Doctor J. Murray Beardsley has had a distinguished record as a surgeon in this state, climaxed with the assignment as surgeon-in-chief of Rhode Island Hospital. He has also been surgeon-in-chief at Chapin Hospital, and he is on the staffs of Roger Williams General, Miriam, Westerly, Woonsocket, and the VA hospitals. He was president of the Providence Surgical Society 1956-57.

concluded on next page

HONORARY MEMBERSHIPS AWARDED

The Rhode Island Medical Society voted honorary memberships to Congressman John E. Fogarty, Mrs. David DeJong, librarian of the Society, and Captain Joseph L. Yon, MC, USN, Commanding Officer of the Newport Naval Hospital, at its business meeting held on May 9, 1962. The awards were voted by the membership on the recommendation of the Council on the occasion of the 150th year celebration of the Society. Membership presentations were made to the three recipients at the Society's annual dinner held in the evening at the Sheraton-Biltmore Hotel.



Mrs. David DeJong, a graduate of Pembroke College, first engaged in medical library work as a part-time assistant to Miss Grace E. Dickerman, librarian of the Medical Society, while still a student at college. She became full-time assistant librarian of the Rhode Island Medical Society in 1932 after her graduation from Pembroke, and after special training in librarianship at the Boston Medical Library under the guidance of Mrs. James Ballard. She assumed the post of librarian of the Society in 1945, and she is one of the foremost authorities in New England on medical literature. Mrs. DeJong is a member of the Rhode Island Medical Librarians, the Rhode Island Library Association, the New England Medical Library Association, Rhode Island Alpha, Phi Beta Kappa, and the Medical Library Association. She is the wife of David C. DeJong, well-known author and teacher.



Captain Yon, a native of Pennsylvania, has been instrumental in bringing about a close alliance between the military and civilian medical personnel in the Newport area since he became commanding medical officer of the U. S. Naval Hospital in 1960.

He is a graduate of the University of Virginia Medical School, and upon the completion of his hospital internship he enlisted in the Navy Medical Corps with his first assignment, in 1938, at Newport Naval Hospital. He served as medical officer aboard the USS *Pecos* in the Asiatic Fleet which was in Manila Bay at the outbreak of the war. He later served in Washington, and then returned to the Pacific theater of war in 1943 as senior medical officer on the USS *Miami*.

He has served as head of the Department of General Surgery at the Naval Hospital at St. Albans, New York, as chief of surgery, and executive officer on the USS *Constellation* in Korea, and as chief of surgery at the Naval Hospital at Camp Lejeune, North Carolina, before assuming the command post at Newport two years ago. He has been the recipient of many military decorations, including a Secretary of Navy Letter of Commendation with pendant, and the Purple Heart, the United Nations Service Medal, Philippine Defense Ribbon with one star, and the Philippine Liberation Ribbon with two stars.



Congressman Fogarty, now completing his twenty-second year as a member of the United States House of Representatives, has been a member of the appropriations committee since 1947, and as chairman for ten years of its important subcommittee providing funds for the departments of Labor and Health, Education and Welfare, he has become nationally known as the spokesman for medical research in Congress.

SOCIETY OFFICERS INSTALLED

concluded from preceding page

Standing Committee Chairmen

Major committees designated as standing committees whose membership is elected by the House of Delegates of the Society, have as their chairmen for the next year the following: Industrial Health, Doctor Thomas J. Dolan, of Providence; Library, Doctor Francesco Ronchese, of Providence; Medical Economics, Doctor Stanley D. Simon, of Providence; Publications, Doctor Alex M. Burgess, of Providence; Public Laws, Doctor Samuel Adelson, of Newport; Public Policy and Relations, Doctor Arthur E. Hardy, of Warwick; Scientific Work and Annual Meeting, Doctor Jesse P. Eddy III, of Providence.

SESQUICENTENNIAL YEAR EXPOSITION OF HEALTH PROGRESS





82,000 PERSONS ATTEND OUR EXPOSITION



WE CUT A BIRTHDAY CAKE



WE TELL ABOUT THE SOCIETY,
ITS ACTIVITIES, ITS LIBRARY



WE INFORM THE PUBLIC



WE INOCULATE THOUSANDS
AGAINST POLIO

Editorials

ACTIONS — NOT WORDS

THE GREATEST audio-visual health education program for the public ever staged in New England attracted more than eighty thousand persons to the Cranston Street Armory in Providence during the period, April 6-14. The Exposition of Health Progress staged by the Society was its 150th birthday celebration gift to the people of Rhode Island. To say it was a success is a gross understatement.

Offering no prizes, presenting no "gimmicks" usual to trade shows, the Society's exposition relied on outstanding medical and health displays, manned by physicians, nurses and technical personnel, to tell its story. The 82,200 who walked through the hall to view the displays, to hear physicians explain the intricacies of human anatomy and methods to cope with illness and disability, attested to the tremendous interest in medicine, and the maintenance of good health.

The exposition was a story of action.

More than 200 members of the Society who served as volunteer lecturers during the week brought anatomical displays to life with their ready answers to every question by the visitor. The remarkable efficiency of the guided tours of schoolchildren every morning under the direction of the Woman's Auxiliary brought praise from veteran fair officials as being the best organized program of its kind they have ever witnessed. The enthusiastic response of many industrial companies to the invitation to sponsor displays, the informative exhibits of health and social welfare agencies, and particularly the dental and veterinary association programs, all contributed to make what our leading newspaper belatedly acknowledged to be "a four-star hit."

The health exposition was two years in the planning, and the originators of the idea to celebrate the Society's sesquicentennial in such a manner certainly never foresaw that it would take place at a time when the medical profession in Rhode Island was to be subject to an unprovoked attack by labor spokesmen, abetted by a seemingly sympathetic press. Both these critics were strangely silent throughout the period of the exposition as the general public responded to the invitation of organized medicine to attend a gigantic free educational display to learn how to protect and retain good health.

Medicine, like religion, must weather many unwarranted attacks in its seemingly slow and methodical search for truth. We have been buffeted these past few months by a welter of allegations, half-truths, political threats, and damaging criticisms by those who seek to besmirch physicians in general. Against the shoutings and writings of these few we turn to the Health Exposition as a demonstration of the public's trust and belief in the physicians of Rhode Island — a trust that the Rhode Island Medical Society will never fail.

TOWN AND GOWN

ON THE EVENING of April 26, 1962, the physicians in the "Brown Family" were the guests of Brown University at a dinner and Symposium in the Sharpe Refectory, at which the proposed "Program for Medical Education" at Brown University was presented. These columns have expressed some concern in the past over the lack of liaison between the authorities responsible for the planning of the program at Brown and the medical community of this area. The dinner was a welcome and well-advised exercise in community relations. The guests were invited both to question and suggest. President Barnaby C. Keeney, Doctor Glidden L. Brooks, and members of the faculty presented in clear and logical form the six-year integrated program which will cover four academic years leading to a bachelor's degree, and two preclinical years leading to a master's degree. The student may then pursue a Ph.D. course at Brown or elsewhere, or seek an M.D. degree which would require two addi-

concluded on next page

tional clinical years at an accredited medical school. As presently projected, this would be elsewhere than at Brown, although it is quite possible that the full course may be available at Brown some time in the future.

The first freshman class, it is hoped, will be accepted in the fall of 1963. There will be no replacements for attrition, and candidates may not enter the final two years unless they have completed the specialized four-year undergraduate training within the special program. Biological or medical studies will be started in the second year and continue through the sixth. Humanities and the arts will start in the first year and will be carried through the fifth. It is claimed that the concentrated program will provide a full ration of both science and the humanities. This will be accomplished by requiring attendance during four summers. It is hoped that scholarship aid will be sufficient to permit this elite group to eschew summer employment. The purpose of the program is to produce highly trained medical scientists.

We have reservations concerning the problem of choosing properly motivated young men so early in their careers. Perhaps experience in selection of candidates gained over a period of years will minimize this problem. We are inclined, however, to anticipate changes in the program toward a more conventional curriculum. One influence which cannot now be estimated is the attitude of the new medical faculty members, otherwise oriented, who must be integrated into the organization. Once engaged, they become voting members of the faculty. Their possible impact upon the program, indirectly referred to at the Refectory dinner, is unpredictable at this time. We should expect it to be in the direction of conventionality.

We have before us a newly issued status report on the thirty-year class of the Harvard Medical School, the class of 1932. It is interesting in this context to examine the accomplishments of the 118 surviving members. Two have retired; one has gone into the ministry. Fifteen are in general practice. The remaining 101 are in some form of specialty practice. Of these, 65, or two-thirds, are certified by specialty boards. Thirty-nine, or one-third, now hold teaching appointments. Among these there are 11 full professors, 12 associate professors, and 6 assistant professors. Thus one quarter of the class have some form of professorship. There are, incidentally, two editors. This is not a bad over-all record for a trade school.

The advent to Rhode Island and Brown University of a new experiment in medical education (we have been cautioned not to call it at this time a "medical school") is most welcome. Whether or not this specific philosophy of medical education will, in the long run, prevail, we extend to Brown University our sincere best wishes for every possible success in the new venture.

(Published on page 301 of this issue is a further statement on the subject by Doctor Brooks.)

THE SESQUICENTENNIAL MEETING

THE One Hundred and Fifty-first Anniversary Meeting of the Rhode Island Medical Society as officially designated, or the Sesquicentennial Meeting as it was popularly called to avoid confusion in the muddled medical brain, is now history (attention Historical Project of the year 2012!). The excellent two-day meeting was held at the Marvel Gymnasium of Brown University on May 8 and 9, 1962. We wish first of all to thank the University for its cordial hospitality.

The plan of holding a full two-day meeting was essentially an innovation, as this format had not proved a feasible one in recent years. Attendance on the off-day was bolstered on the present occasion somewhat by the excellence of the program and the availability of ample parking space. Medical films and scientific exhibits were worthwhile additions made possible by increased floor space. In addition, more than the usual number of technical or commercial exhibits could be accommodated.

Without pointing to individual features or presentations, it is possible to state that the program was of a generally high order. There were the inevitable "bugs" expected in a new venture; but the responsible officers are already taking note of these with a view to eliminating them another year. Doctor Jesse P. Eddy III and his Committee on Scientific Work should be encouraged to pursue this experiment in coming years, and we congratulate them for a superior performance.

Invest in the future health of the nation and your profession

Give to medical education through AMEF

American Medical Education Foundation AMEF 535 N. Dearborn St. Chicago 10, Ill.



For peptic ulcer gastric hyperacidity and gastritis...

In year-long study on peptic-ulcer patients

New Creamalin®
Antacid Tablets

*"...faster in onset of action...and for a longer period"**

"Clinical studies in 85 patients with duodenal ulcer ...confirmed the superiority of the new preparation [new Creamalin] over standard aluminum hydroxide preparations, in that prompt relief was achieved and maintained throughout the period of observation."*

Patients were followed for about one year.

New Creamalin promotes ulcer healing, permits less frequent feedings because it is so long-acting. Heartburn and epigastric distress were "...easily and adequately controlled...."* New Creamalin has the therapeutic advantage of a liquid antacid with the convenience of a palatable tablet. *It does not cause constipation.*

Each new Creamalin tablet contains 320 mg. of specially processed highly reactive dried aluminum gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. Minute particles offer a vastly increased surface area.

Dosage: Gastric hyperacidity—from 2 to 4 tablets as needed. Peptic ulcer or gastritis—from 2 to 4 tablets every two to four hours. *How Supplied:* Bottles of 50, 100, 200 and 1000.

Now also available—New Creamalin Improved Formula Liquid. Pleasant mint flavor—creamy pink color. Stabilized reactive aluminum and magnesium hydroxide gel (1 teaspoon equals 1 tablet). Bottles of 8 and 16 fl. oz.

Creamalin, trademark reg. U.S. Pat. Off.

*Schwartz, I. R.:
Current Therap. Res. 3:29, Feb., 1961.

Winthrop LABORATORIES New York 18, N. Y.

HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY
Report of Meeting Held April 30, 1962

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library in Providence on Monday, April 30, 1962. The meeting was called to order by the president, Doctor Samuel Adelson, at 8:05 P.M. The following delegates were in attendance:

BRISTOL COUNTY: Robert W. Drew, M.D. *KENT COUNTY:* Peter C. Erinakes, M.D.; Edmund T. Hackman, M.D., and John M. Vesey, M.D. *NEWPORT COUNTY:* (no delegates present). *PAWTUCKET DISTRICT:* Earl F. Kelly, M.D. *WASHINGTON COUNTY:* Freeman B. Agnelli, M.D., and Joseph Ruisi, M.D. *OFFICERS OF THE RIMS* (other than delegates): Samuel Adelson, M.D.; Frank I. Matteo, M.D.; Arthur E. Hardy, M.D.; Michael DiMaio, M.D., and J. Murray Beardsley, M.D. *PROVIDENCE MEDICAL ASSOCIATION:* Robert R. Baldridge, M.D.; John T. Barrett, M.D.; Irving A. Beck, M.D.; J. Robert Bowen, M.D.; Wilfred I. Carney, M.D.; Francis H. Chafee, M.D.; Warren Francis, M.D.; Frank Fratantuono, M.D.; J. Merrill Gibson, M.D.; John F. W. Gilman, M.D.; Seebert J. Goldowsky, M.D.; Stanley Grzebien, M.D.; Waldo O. Hoey, M.D.; Robert V. Lewis, M.D.; William J. MacDonald, M.D.; Gustavo A. Motta, M.D.; William S. Nerone, M.D.; Arnold Porter, M.D.; Ralph D. Richardson, M.D.; Jack Savran, M.D.; Carl S. Sawyer, M.D.; Stanley D. Simon, M.D.; John Turner II, M.D., and Elihu S. Wing, Jr., M.D., Henry B. Fletcher, M.D. *DELEGATE TO A.M.A.:* Charles J. Ashworth, M.D.*

Also present was John E. Farrell, SC.D., executive secretary, and the following members of the Society: Doctors Thomas Perry, Jr., Peter Mathieu, A. A. Savastano, Francis B. Sargent, A. Jaworski, Francis Hanley, and Jesse P. Eddy III.

REPORT OF THE SECRETARY

Doctor DiMaio, secretary of the Society, read his report, copy of which was included in the handbook to the delegates.

ACTION: It was moved that the report be approved and placed on file. The motion was seconded and adopted.

(*without vote)

REPORT OF NOMINATIONS COMMITTEE

The president called to the attention of the delegates that the Council, acting as a nominations committee under the by-laws regulations, had submitted a list of nominees for officers and standing committees to serve for 1962-63. He noted that the list of nominees was included in the handbook to the delegates and that counter nominations may be made from the floor by any delegate.

The slate proposed:

Nominees for Officers for 1962-1963

President ... ARTHUR G. HARDY, M.D. (Warwick)
Vice President ... ROBERT R. BALDRIDGE, M.D., (Providence)
President-Elect ... THOMAS PERRY, JR., M.D., (Providence)
Secretary ... MICHAEL DIMAIO, M.D. (Providence)
Treasurer ... J. MURRAY BEARDSLEY, M.D., (Providence)

STANDING COMMITTEES: (President and secretary, *ex officio*, members of all Standing Committees).

Nominees for 1962-1963

COMMITTEE ON INDUSTRIAL HEALTH: Thomas J. Dolan, M.D., chairman (Providence); George F. Conde, M.D. (Providence); A. Lloyd Lagerquist, M.D. (Providence); Francis L. McNelis, M.D. (Providence); John Murphy, M.D. (Warwick); John B. Nally, M.D. (Newport); Paul J. Rozzero, M.D. (Providence); Stanley Sprague, M.D. (Pawtucket), and Michael A. Tarro, M.D. (Providence).

LIBRARY COMMITTEE: Francesco Ronchese, M.D., chairman (Providence); Janis Gailitis, M.D. (Newport); Manuel Horwitz, M.D. (Providence); William MacDonald, M.D. (Providence); George V. Coleman, M.D. (Providence); John D. Pitts, M.D. (Providence); Jeannette E. Vidal, M.D. (West Warwick); Johannes Virks, M.D., and Francis P. Vose, M.D. (Woonsocket).

COMMITTEE ON MEDICAL ECONOMICS: Robert C. Hayes, M.D., chairman (Pawtucket); Stanley D. Simon, M.D. (Providence); Charles B. Ceppi, M.D. (Jamestown); Peter Eri-

nakes, M.D. (Warwick); John F. W. Gilman, M.D. (Providence); James McGrath, M.D. (Wakefield); Gustavo A. Motta, M.D. (Providence); Michael G. Pierik, M.D. (Providence), and John Turner II, M.D. (Providence).

COMMITTEE ON PUBLICATIONS: Alex M. Burgess, M.D., chairman (Providence); Bertram H. Buxton, Jr., M.D. (Providence); John A. Dillon, M.D. (Providence); Seebert J. Goldowsky, M.D. (Providence); Robert V. Lewis, M.D. (Providence); Peter L. Mathieu, M.D. (Providence); José M. Ramos, M.D. (Newport); Robert W. Riemer, M.D. (Providence), and Lester L. Vargas, M.D. (Providence).

COMMITTEE ON PUBLIC LAWS: Samuel Adelson, M.D., chairman (Newport); Freeman B. Agnelli, M.D. (Westerly); Frank D. Fratantuono, M.D. (Providence); Auray Fontaine, M.D. (Woonsocket); Stanley T. Grzebien, M.D. (Providence); Edmund T. Hackman, M.D.; William A. McDonnell, M.D.; P. Joseph Pesare, M.D., and William A. Reid, M.D.

COMMITTEE ON PUBLIC POLICY AND RELATIONS: Arthur E. Hardy, M.D., chairman (Warwick); Michael DiMaio, M.D. (Providence); Thomas Perry, Jr., M.D. (Providence); Samuel Adelson, M.D. (Newport), and Arnold Porter, M.D. (Providence).

COMMITTEE ON SCIENTIFIC WORK AND ANNUAL MEETING: Jesse P. Eddy III, M.D., chairman (Providence); J. Murray Beardsley, M.D. (Providence); Alex M. Burgess, Sr., M.D. (Providence); Kenneth G. Burton, M.D. (Providence); John A. Dillon, M.D. (Providence); Marshall N. Fulton, M.D. (Providence); Henri E. Gauthier, M.D. (Woonsocket); A. A. Savastano, M.D. (Providence), and Lester L. Vargas, M.D. (Providence).

ACTIONS: The motion was made that the slate of nominees for officers to serve for 1962-63 be closed and that the secretary be instructed to cast a ballot for the House electing the nominees submitted by the Council. The motion was seconded and passed.

* * *

On separate motions the nominations were closed and the secretary was instructed to cast a ballot for the House electing the committee members for the following committees:

Industrial Health, Library, Publications, Public Laws, Public Policy, and Scientific Work and Annual Meeting.

* * *

A counter nomination was made for Doctor John F. W. Gilman to be chairman of the Committee on Medical Economics.

A counter nomination was made for Doctor Stanley D. Simon to be chairman of the Committee on Medical Economics. In each case the motion was seconded.

Doctor Gilman asked that his name be withdrawn as a nominee.

On a written ballot, Doctor Stanley D. Simon was declared elected chairman of the Committee on Medical Economics.

Resolutions

1. Dr. John F. W. Gilman introduced the following resolution:

WHEREAS the committee in charge of the Health Progress Exposition has performed a most valuable service for the Medical Society and produced an exposition of great distinction which has reflected credit on all the members of this Society, and

WHEREAS the exposition has provided a most effective public commemoration of this Society's Sesquicentennial Celebration attested to by over 80,000 visitors, and

WHEREAS the Woman's Auxiliary has likewise aided immeasurably in the success of this venture,

THEREFORE BE IT RESOLVED that this House now commend the committee and the Woman's Auxiliary and extend its grateful thanks and sincere appreciation for an arduous job well done.

ACTION: The resolution was unanimously adopted by the house.

* * *

2. Doctor Earl F. Kelly, delegate from the Pawtucket Medical Association, reported that at a regular meeting of that Association held on April 19, 1962, the following resolution was adopted:

THAT the Rhode Island Medical Society recommend that the Rhode Island Physicians Service evaluate and consider the newly adopted policy of the Massachusetts Blue Shield which renders full coverage for medical illness of a severe and critical nature.

Doctor Kelly requested that Doctor Alex Jaworski be permitted to address the House on the resolution.

Doctor Jaworski reported that the Pawtucket Medical Association was concerned with the problem of insurance coverage of severe illness for in-hospital patients, and he cited a case involving the care of a subscriber to the Massachusetts Blue Shield plan where complete payment was made for

continued on next page

physicians' services rendered during a serious illness.

ACTION: A motion was made, seconded and passed that the communication be received and referred to the Committee on Medical Economics.

REPORT OF SESQUICENTENNIAL COMMITTEE

Doctor Thomas Perry, Jr., general chairman of the Sesquicentennial Committee, reported that a complete and detailed report of the Sesquicentennial would be filed at a later date. At this meeting he brought to the attention of the House the fact that there were oustanding debts in connection with the Exposition of Health Progress of approximately $9,500 with little more than $5,000 in cash on hand for payment, thus leaving a deficit of almost $4,500.

He noted that member assessments due plus outstanding accounts would realize over $2,900 when collected, leaving a possible final deficit of approximately $1,500.

He noted that the House must decide whether to consider another assessment of the membership or whether it wishes to use Society funds to pay the deficit.

The president noted that under the by-laws members are not in good standing if they fail to pay their dues and any special assessment made by the House of Delegates.

ACTION: It was moved that the report of the chairman of the Sesquicentennial Committee be received and that the House vote to pay the outstanding debts out of available Society funds. The motion was seconded and adopted.

REPORT OF THE COMMITTEE ON PREVENTION AND TREATMENT OF ATHLETIC INJURIES

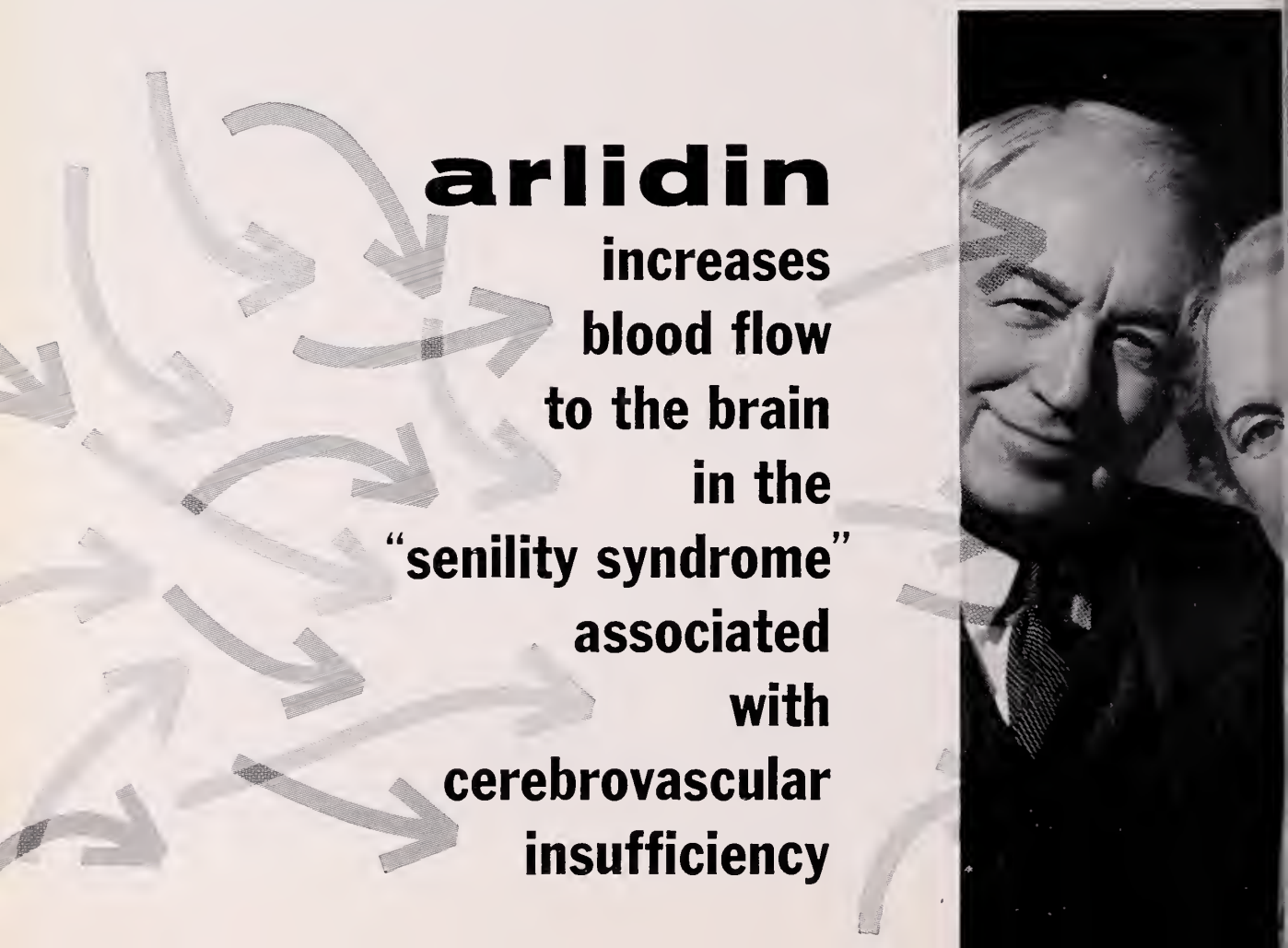
Doctor A. A. Savastano reported that a second annual conference on the prevention and treatment of athletic injuries would be held on September 10 at Brown University. He stated that the committee is currently working on the program and that it also has been helpful in providing information to various groups concerned with athletic injury problems.

ACTION: It was moved that the report be received and placed on file. The motion was seconded and adopted.

REPORT OF THE GRIEVANCE COMMITTEE

Doctor Francis B. Sargent reported briefly on the activities of the Grievance Committee.

He also discussed the name of the committee which he felt was misleading to some persons who have recourse to it. He suggested the change be



made to call it a committee on mediation. It was moved that the report of the chairman of the grievance committee be approved and that the delegates recommend to the membership at the annual business meeting that the title of the present committee on Medical Defense and Grievance be changed to Mediation Committee.

The motion was seconded and passed unanimously.

COMMITTEE REPORTS

On separate motions the reports of the following committees were received, approved and placed on file: Benevolence Fund, Cancer Committee, Child-School Health Committee, Disaster Committee, Industrial Health, Library, Maternal Health, Mental Health, Publications, Public Laws, Science Fair, Social Welfare, and Woman's Auxiliary.

SCIENTIFIC WORK AND ANNUAL MEETING

Doctor Jesse P. Eddy III, chairman of the Committee on Scientific Work and Annual Meeting, gave a brief oral report, and he urged full support by members of the Society of the annual meeting program by attendance at the lectures on the Tuesday and Wednesday. A motion that the report be received was seconded and passed.

RESOLUTION REGARDING J. HAROLD WILLIAMS

Doctor Ralph D. Richardson presented the following resolution for consideration by the House:

THAT the Rhode Island Medical Society extend to Mr. J. Harold Williams at the time of his retirement as Chief Executive of the Narragansett Council, Boy Scouts of America, after over forty years of outstanding service to the youth of Rhode Island and to the community, an expression of its esteem for a distinguished career and its felicitations for the future.

The motion was seconded and unanimously adopted.

MEETINGS OF THE HOUSE

Doctor John Turner II discussed the advisability of more frequent meetings of the House of Delegates. He moved that the House hold regular meetings in the months of January, March, May, September, and November. The motion was seconded.

There was discussion of the motion and the following amendment was made: That the House of Delegates hold four regular meetings during the year. The motion was seconded.

* * *

A motion was made to lay the matter on the table. The motion was seconded.

continued on next page



Inadequate cerebral blood flow—often due to cerebral arteriosclerosis—may result in the "senility syndrome" with its pattern of mental confusion, memory lapses, depression, fatigue, apathy and behavior problems.[1-3]

43% increase in cerebral blood flow with Arlidin[4]

In patients with cerebrovascular insufficiency, Eisenberg[4] measured a 43 percent increase in blood flow in the brain following administration of Arlidin orally for more than two weeks beginning with a dosage of 12 mg. t.i.d. and increasing to 18 mg. t.i.d. There was a decrease in cerebral vascular resistance in most instances.

Winsor and associates[3] found Arlidin "of particular value **clinically** in relieving some of the symptoms of cerebral vascular insufficiency (vertigo, lightheadedness, mental confusion, diplopia)."

arlidin®

(BRAND OF NYLIDRIN HCl NND)

references: 1. Madow, L.: Penn. M. J. 62:861, June 1959. 2. Stieglitz, E. J.: Geriatric Medicine, ed. 2, Philadelphia, Saunders, 1949 p. 274. 3. Winsor, T., et al.: Amer. J. Med. Sciences 239:594, May 1960. 4. Eisenberg, S.: ibid, July 1960.

NOTE—before prescribing ARLIDIN the physician should be thoroughly familiar with general directions for its use, indications, dosage, possible side effects and contraindications, etc. Write for complete detailed literature.

u. s. vitamin & pharmaceutical corporation

Arlington-Funk Labs., division • 800 Second Avenue, New York 17, N. Y.

The motion to lay on the table was defeated.
The motion to amend was defeated.
The original motion was defeated.

ADJOURNMENT

Doctor Adelson expressed his appreciation to the House of Delegates for the co-operation they had given him throughout the year.

The meeting was adjourned at 11:00 P.M.

Respectfully submitted,
MICHAEL DIMAIO, M.D., *Secretary*

REPORT OF THE SECRETARY

At the March meeting of the Council the following were among actions taken:

1. The Council was in agreement that the special assessment for the Sesquicentennial Celebration of the Society was binding on all members, and it directed the president to send a letter to every member who had not paid the assessment.

2. The State Director of Health was requested to submit any legislation arising from his department involving medicine and public health to the Society's committee on public laws prior to General Assembly introduction.

3. Approval was given for three senior and three junior high school science fair awards.

4. The president was authorized to name a committee to study the entire problem of expansion of the staff and facilities of the executive office, the committee to report to the Council at a subsequent meeting, either at or prior to the September meeting of the Council.

5. The president was authorized to appoint a committee to meet with the Rhode Island Osteopathic Society for consideration of mutual problems if and when there is need for such a meeting.

6. A proposal of the U.S. Department of Health, Education and Welfare to conduct a health examination survey in Rhode Island was approved.

7. The Council voted to assemble as the Society's ethics and deportment body on a matter involving physicians' ethics.

8. A slate of nominees of Officers and Standing Committees to serve until the annual meeting in May, 1963, was approved for submission to the House of Delegates.

MICHAEL DIMAIO, M.D., *Secretary*

BENEVOLENCE FUND

During 1961 the trustees of the Benevolence Fund extended financial aid to three physicians and/or their families.

A summary financial report for the year 1961 follows:

Cash balance, Savings Department, Industrial National Bank, Providence, R.I., January 1, 1961	$ 9,926.87
Receipts, all sources, 1961	3,462.00
Interest on Savings Account, 1961	365.59
Total assets	$13,754.46
Benefits paid to three families, 1961	1,200.00
Cash balance, Savings Account, Industrial National Bank, Providence, R.I., January 1, 1962	$12,554.46

* * *

The trustees express their appreciation to the members of the Society and the Woman's Auxiliary for their continued support of this Fund.

The trustees also ask authority from the House of Delegates to explore ways in which the Fund may be invested to provide a higher income, if possible, than is realized currently.

Respectfully submitted,
DAVID FREEDMAN, M.D., *Chairman*
HENRY J. HANLEY, M.D.
GEORGE W. WATERMAN, M.D.

CANCER

The duties and services of the Cancer Committee of the Rhode Island Medical Society for this year have largely come to an end, though we are still continuing an evaluation of the possibility of using proctosigmoidoscopy more frequently in cancer detection examinations.

The physicians who staff these clinics have been circularized, and their interest in or knowledge of the sigmoidoscope has been appraised.

Our recent Cancer Seminar, stressing diseases of the colon and rectum, was well received and well attended, and the Committee has received grateful notes of thanks from the participants.

Further details of our activities will probably be delayed until the announcement of the new Committee and new chairman at the next annual meeting.

Respectfully submitted,
HENRY C. MCDUFF, JR., M.D., *Chairman*

CHILD-SCHOOL HEALTH

Over the course of the past year the Committee has made a number of recommendations some of which are awaiting implementation.

The Committee has recommended that there be established a uniform code throughout the state concerning the handling of contagious diseases with particular regard to the school systems. This has been endorsed by the director of Health of the state and a number of the larger school systems but at the moment we have no way of putting them into effect.

The Committee has been consulted regarding tuberculin testing in the various school systems. Such a program has been carried out in Warwick

continued on page 320



Emotional control regained...a family restored... thanks to a doctor and 'Thorazine'

During the past seven years, 'Thorazine' has become the treatment of choice for moderate to severe mental and emotional disturbances because it is:

- specific enough to relieve underlying fear and apprehension
- profound enough to control hyperactivity and excitement
- flexible enough so that in severe cases dosage may be raised to two or three times the recommended starting level

Experience in over 14,000,000 Americans confirms the fact that, in most patients, the potential benefits of 'Thorazine' far outweigh its possible undesirable effects.

Of special value in mental and emotional disturbances: Tablets for initial therapy; Injection (Ampuls and Vials) for prompt control; Spansule® sustained release capsules for all-day or all-night therapy with a single oral dose.

Smith Kline & French Laboratories SK&F

Thorazine®

brand of chlorpromazine

A fundamental drug
in both office and hospital practice

For prescribing information, please see PDR or SK&F literature.

Posed by professional models.

HOUSE OF DELEGATES

continued from page 318

with apparently little being gained. It was felt that the expensive and tedious method of intracutaneous testing might be supplanted by the Patch test. The recently developed Tine test is expensive but quick and easy.

The Committee endorsed the use of test material for the detection of phenylketonuria as outlined by the Rhode Island State Department of Health.

A recommendation of the Rhode Island Ophthalmological Society for preschool vision testing was endorsed and it was suggested that the Ophthalmological Society make specific recommendations to this Committee and the Rhode Island Medical Society.

The Committee has concerned itself with the plans for the "Health Exposition" which was held at the Cranston Armory in April. These plans were reviewed and endorsed.

A review of the use of psychiatric social workers in the public school systems was made. It was the opinion of the Committee that we evaluate the experiences of the Barrington School System over the past few years and make a recommendation at a later date. I suggest that the *Report on Psychiatric Services to Emotionally Disturbed Children in Rhode Island,* a report from the Rhode Island Council of Community Services, be used to aid the committee in its future deliberations.

The Committee has suggested that the use of the oral poliomyelitis vaccine, when it becomes available this year, be confined to the private physicians for this year and not be used in large public service clinics unless there is an epidemic situation. In the latter event, the oral vaccine should be used to "blanket" the state.

Respectfully submitted.

JOHN T. BARRETT, M.D., *Chairman*

DISASTER

There is not much additional information to report to the House since the written report submitted for the Committee at the January meeting of the Delegates.

At the present time the Self-Help Program is being implemented throughout the state. Several members of the Committee are conducting classes of instruction in the district societies, and information gained from these ventures is reported to the state director of the program, and also to the Department of Defense in Washington.

FRANCIS E. HANLEY, M.D., *Chairman*

INDUSTRIAL HEALTH

The Industrial Health Committee of the Rhode Island Medical Society has been primarily concerned during the year with legislative proposals now before the Rhode Island General Assembly to make permanent occupational deafness compensable under the Workmen's Compensation Act. Meetings and correspondence with specialists in this field, local business interests, the Chamber of Commerce, insurance representatives, etc., have been held. The Textile Industry in our state is particularly interested and concerned due to the high noise levels associated with this type of industry.

At a recent meeting, on March 21, 1962, with five specialists in otology, the Committee felt that any bill, to be acceptable to all groups concerned, should be patterned after the American Medical Association's *Guide to the Evaluation of Permanent Impairment of the Ear, Nose and Throat.* Correspondence with the subcommittee on noise of the American Academy of Ophthalmology and Otolaryngology affirms this position.

A questionnaire concerning any interest and or affiliation with industry and industrial medicine or surgery was forwarded to all members of the Society early in the year. The results are at present being tabulated and will be reported at a later date.

Your chairman, with the Industrial Health chairmen of the other New England State Medical Societies and the members of the Massachusetts Committee on Occupational Health, and others, made up the Program Planning Group, with meetings in Boston, for the 1962 A.M.A. Congress on



Industrial Health to be held this year in Boston in October.

Respectfully submitted,
THOMAS J. DOLAN, M.D., *Chairman*

LIBRARY

The Sesquicentennial celebration, the collecting of portraits and biographies of members of the Society for the past 150 years, has added considerably to the normal activities of the librarians. Checking each page of books and periodicals for defects, filing, exchanging material with other libraries, answering the general public queries on all sorts of medical topics, referring same to the proper channel, helping the investigative physician with the time consuming search of references, helping the boys and girls of our local schools with their paramedical problems, taking active part in librarians' meetings throughout the country, and many other tasks were accomplished in an expert manner by the librarian, Mrs. Helen DeJong, assisted by Miss Deborah Clarke and Miss Grace Dickerman.

The Committee is happy that our Librarian *Emerita* has resumed her duties after a period of disability and we offer her our best wishes.

Respectfully submitted,
FRANCESCO RONCHESE, M.D., *Chairman*

* * *

Report of the Librarian

We have been enjoying the company of Doctors Throop, Parsons, Newell, Eldredge, Mauran, King, Snow and many other fascinating gentlemen this past year and it has been an interesting experience. From the pages of the old record books, these figures of history became alive, stating their reasons for the formation of the Rhode Island Medical Society, their belief in medical research and their hopes for a library.

So much time was spent in the past, that the present suffered somewhat. For instance, we wish to apologize to our Friends of the Library for not publishing an acknowledgment of their many gifts since 1960. Such a list will be the top priority item for the summer months.

The possibility of microfilming some of our unbound periodicals (and thus winning the Battle of the Bulge) was discussed. However, the expense plus the need for proper storage of films caused us to put the idea aside for the present. We think we can solve the problem, temporarily, by some checkerboard moves and some judicious pruning. This, too, will be a summer project.

Last July we started cleaning and polishing the rare books and managed to do over a hundred before a forced postponement in the fall. In addition, seven of our most valuable items were repaired by Mr. Knowlton of Brown University. We hope to resume the care and feeding of old leather this year.

The statistics for April 2, 1961 through March 31, 1962 are as follows: We received 1,035 bound volumes through purchase, review, gift and conversion; of these, 578 were duplicates. In addition to these, we had gifts of periodicals, pamphlets, instruments, phonograph records and letters. Our present total is 43,580 of which 32,701 bound volumes have been catalogued. 4,833 unbound volumes and pamphlets have been catalogued and many more are waiting. Our readers numbered 2,511 (1,304 physicians; 1,207 general public) and our circulation figures showed 1,545 periodicals borrowed; 395 textbooks including 70 from the Davenport Collection. The circulation figures do not give an accurate picture of the number of items used by library customers, of course, as much of the reading is done here. The average reader uses from three to five references, ten or more are not uncommon and one person checked sixty-seven articles in one afternoon! We prepared 332 bibliographies. We are receiving 451 periodicals and serials. Our interlibrary loan figures show that 527 journals, 38 books, 6 phonograph records and 1 photograph were borrowed by other libraries (several from out-of-state) while we requested 24 journals, 3 books and 3 photostats. We have verifaxed several

continued on next page

AIR AMBULANCE SERVICE

To any part of the country — day or night. Multi-engine equipment, air line rated pilots. Fully equipped amblance, stimulant tray, oxygen therapy etc. Registered nurse on all trips. We can transport stretcher cases in and out of the smallest airports.

No increase in rates over ground transportation

CUSHMAN'S
AIR AMBULANCE SERVICE

47 NISBET ST., PROVIDENCE, RHODE ISLAND
Call DE 1-4840

items. The Medical Library Association Exchange has sent us 11 single periodical issues (one of which completed our run of the JOURNAL OF CLINICAL INVESTIGATION) and one book. From our file of duplicates we have given 909 single copies and 81 bound volumes to local libraries and have sold 5 volumes.

MRS. HELEN M. DEJONG, *Librarian*

MATERNAL HEALTH

Because of the smaller number of maternal deaths during the past year, only two meetings have been held by this committee since our 1960 annual report. The first meeting was held on July 25, 1961, at the summer home of Doctor John Carey in Newport. Our Society president, Doctor Adelson, was a guest at that meeting. Some aspects of the new birth certificates were discussed with Doctor Corrigan, but no action was taken. The second meeting was held at the home of the chairman on January 13, 1962. At this meeting Doctor Beddoe, chief medical examiner for the State of Rhode Island, was an invited guest. We discussed the problem of working with Doctor Beddoe in obtaining more autopsies on cases of sudden maternal deaths where the diagnoses were rather obscure. This has been a problem of the committee for some time, and this year two of our cases were unclassified because of lack of definitive data.

At this meeting also a communication was read from the American Medical Association urging that we try to have our legislature pass a bill which would protect us from litigation if we published some of our transactions and case reports for educational purposes. A copy of the recent bill enacted by the Nebraska legislature was read which could be an example for us to follow. Doctor Reid was appointed to use his political influence with some of the legislators to pass such a bill in Rhode Island.

There were only nine maternal deaths during the year 1961 which is one of the lowest in the records of the committee. In 1959 we also had only nine cases. To the best of our ability, the causes of the deaths were grouped and classified as follows:

Direct Obstetric Deaths: (1) Rupture of the uterus, and (2) Post-caesarean section — pulmonary embolus.

Indirect Obstetric Deaths: (1) Lobar pneumonia; (2) Acute appendicitis with peritonitis; (3) Coarctation of the aorta, and (4) Gastrointestinal hemorrhage with adrenal infarction.

Non-related Deaths: (1) Schizophrenia with suicide.

Unclassified: Two deaths that occurred in the puerperium at home where data was insufficient to classify.

With 19,332 births in Rhode Island in 1961 and only two direct obstetric deaths, our obstetric death rate was only one per 10,000 compared to the national rate of 3.8. Because of the two unclassified cases mentioned above, however, this rate may not be valid.

Only two of the cases reported above were considered by the committee to be preventable and one of these was the patient's responsibility. This speaks very well for obstetric care in Rhode Island. Again this annual report shows that the three major causes of maternal mortality — toxemia, hemorrhage, and puerperal infection, which have been a problem over the centuries, are practically extinct in Rhode Island. Most of the deaths are due to unusual and bizarre causes which are not due to the pregnancy.

The chairman would like to take this opportunity to thank Doctor and Mrs. Carey for their hospitality last summer and to thank the various members of this committee for our record attendance at the various meetings over the years. It would be particularly important to thank Doctor Beezer, our secretary, who has been very conscientious and thorough in gathering the data for our case studies for the past four years.

Respectfully submitted,

STANLEY D. DAVIES, M.D., *Chairman*

MENTAL HEALTH

In looking back over the past year the Committee on Mental Health has had some successes and also some failures with respect to some of its long-range objectives. One long-range objective has been to acquire a position of respect for its considered judgments in matters pertaining to mental health and mental illness. A change in the political administration of the state government presented a problem to the Committee. Under the previous administration, the Committee's counsel and help had come to be sought by the Department of Social Welfare. The new administration, from the point of view of patronage consideration, bypassed this Committee. The superintendent of the State Hospital was, in the Committee's opinion, placed in the position where his energies were diverted to fight against the appointment of personnel who were not qualified. The concept that the superintendent of the State Hospital should be facilitated in his functioning rather than hindered by administrative directives from the State House was once again strongly advocated by your Committee. The Committee's success in this regard was not great but the Committee's disapproval of the use of positions at the State Hospital for patronage purposes was stated in meetings with Mr. Albert Russo and Doctor John Pelosi. It is to be regretted that the change in organization of the State Infirmary and the State

continued on page 324



in arthritis: vitamins <u>are</u> therapy

n dealing with the chronic stress of arthritis the physician often faces the problem of nutritional imbalance. High potency B and C supplementation is needed for rapid replenishment of tissue stores of these water-soluble vitamins. STRESSCAPS meet this need and help support the natural metabolic defenses in the disease. Supplied in decorative "reminder" jars of 30 and 100.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y. Lederle

STRESSCAPS®

Stress Formula Vitamins Lederle

HOUSE OF DELEGATES

continued from page 322

Hospital was effected with the Department of Social Welfare not seeking any counsel, to the best of the Committee's knowledge. Distorted and exaggerated claims were made for this reorganization bringing into being the Rhode Island Medical Center. The local Association for Mental Health aided and supported the Committee in its attempts to eliminate the factor of patronage.

The Joint Commission on Mental Illness and Health published its report during the past year. The report was subject to critical analysis by the Committee. It was considered that certain local conditions required modifications of the Commission's recommendations. The Association for Mental Health took action with respect to a recommendation that a physician specializing in psychiatry should head the state department. Certain of your Committee members gave considerable of their time to tailor this recommendation appropriately to the local situation. It was regrettable that in the accounts of the deliberations on this recommendation your Committee's representative was disregarded in the circulated reports of these deliberations. It is to be observed that there are so many fingers in the pie pertaining to mental health and illness, with each finger having a different motivation, that chaos rather than orderly evolution tends to be prevalent. The Committee has taken pleasure in observing that Doctor Sidney Goldstein has had the courage and the tact to prevent this chaos from hampering the care and treatment of patients.

As the year ends the Committee has been occupied in aiding the A.M.A. Council on Mental Health in arranging for a National Congress on Mental Illness and Health in Chicago in October of 1962. Certain members of the Rhode Island Medical Society will be called upon to participate in this Congress. We feel confident that the membership will wholeheartedly co-operate.

To a certain nucleus of the Committee your chairman would like to report that they have enjoyed representing the Rhode Island Medical Society in a very pertinent field of health. It would be the Committee's pleasure to have the House of Delegates initiate additional objectives and direction for its Committee on Mental Health to be guided by.

HAROLD W. WILLIAMS, M.D., *Chairman*

PUBLICATIONS

For the first time in many years the Rhode Island Medical Journal was operated at a deficit as the result of a decrease in pharmaceutical advertising from national accounts. Several factors are involved in the decrease in such advertising, notably the new Food and Drug Administration regulations which have forced manufacturers to extreme caution in all statements regarding products, and the extended Congressional hearings which have had their impact on the pharmaceutical industry.

Operating costs were $3,525 over revenue in 1961, and this deficit was met from the Journal reserve funds. However, this fund will not be able to withstand a similar deficit in 1962, and therefore your Committee calls the matter to the attention of the House and suggests that consideration be given at the September meeting to the inclusion of a subsidy from the Society to offset the Journal loss this year.

Your Committee believes that the Rhode Island Medical Journal serves a vital purpose as the official publication of this Society. We have endeavored to maintain the high standard that has been set through the years, and we are most reluctant to reduce the content size of the issues to offset the advertising revenue loss.

Respectfully submitted,
ALEX M. BURGESS, M.D., *Chairman*

PUBLIC LAWS

The January 1962 session of the Rhode Island General Assembly was adjourned at 2:30 A.M. on Sunday, April 15 on the 60th day which began on Friday, April 13 at 1:00 P.M. In this final hectic



Health Havens
100 WAMPANOAG TRAIL
EAST PROVIDENCE, R. I.
438-4275

A Truly Modern, Intermediate Care Facility Providing the Ultimate in Nursing Home Care at Reasonable Rates

Prepared to accept and adequately care for many acute cases as well as the more general convalescent and nursing home patients. We are limited to adults.

Our Nursing Administrator, Mary E. Baxter, R.N., will be pleased to discuss patient care with you.

Paul E. Morin, *Adm.*

day over 300 bills were sent to the governor, including two which the Society protested strongly, and which the governor ultimately vetoed.

An estimated 1,500 bills were introduced during the session, and all were checked in general by the executive officer of the Society, and any pertaining to medical, public health, welfare and allied matters were carefully reviewed and brought to the attention of the Committee on Public Laws.

For the Society the Committee on Public Laws notified committees of the General Assembly, and the governor, of its opinion on various legislative proposals. Members of the Society joined with legal counsel and officials of Physicians Service to protest bills that would make chiropractic physicians participating doctors under the voluntary prepaid insurance program.

The executive secretary joined with the state director of Health in presenting objections to the weakening of the basic science statute to permit chiropractic physicians to qualify for the examination without the requirement of a year of preprofessional education in an academic college.

Both these bills affecting chiropractic were passed in the final 37½-hour session, and after protest from physicians the governor vetoed the bills.

Major legislation involving health and welfare that was passed included the following:

A requirement for seat belts in all new automobiles beginning with 1964 models.

Amendment of the Providence Minimum Housing Standards Act to require hot water facilities in houses, a proposal that had the support of the Providence Medical Association.

Bills extending mental health services.

Abolishment of the milk control board and establishment of a milk sanitation code under the department of health.

Creation of a "blue ribbon" commission to study medical and hospital costs, the operation of the Blue Plans, and the expansion of hospital facilities in Rhode Island, with a report to be made by September 1.

Licensure for those who would qualify as physical therapists.

Redefinition of the professional regulations affecting physicians and surgeons, and podiatrists.

Several amendments affecting the social welfare program and the state institutions, as noted in the summary on legislation that follows.

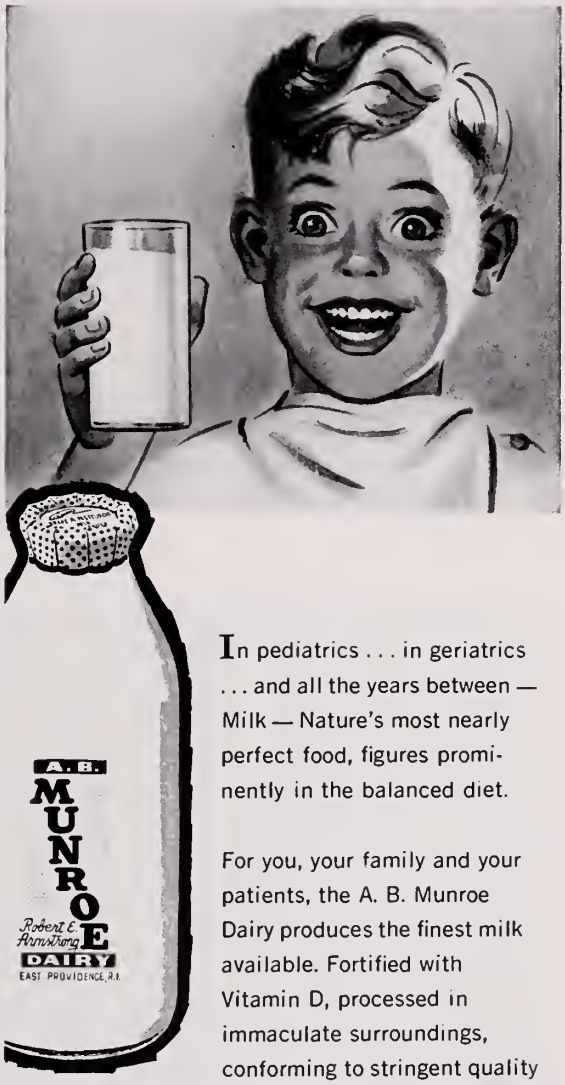
COMMITTEE ON PUBLIC LAWS
F. B. AGNELLI, M.D., *Chairman*

SCIENCE FAIR

The 1962 Rhode Island Schools Science Fair did not, in the opinion of your Committee, approximate the high level of the Fairs of the past two years. However, the medical and health displays selected

continued on next page

"your very good health"



In pediatrics . . . in geriatrics . . . and all the years between — Milk — Nature's most nearly perfect food, figures prominently in the balanced diet.

For you, your family and your patients, the A. B. Munroe Dairy produces the finest milk available. Fortified with Vitamin D, processed in immaculate surroundings, conforming to stringent quality requirements, A. B. Munroe milk is the ultimate in purity and safety.

RHODE ISLAND QUALITY MILK ASSOCIATION MEMBER

A. B. MUNROE DAIRY, INC.
151 Brow Street, East Providence, Rhode Island

Call GE 8-4450
for Home Delivery

for awards were certainly among the finest of all the exhibits in the Fair. One of the Society's awards made prior to the selections by the school officials judging the displays, was made to Miss Barbara Marzocchi for her exhibit on "Vital Energy," and this exhibit was eventually selected as one of the two best in the entire show.

The selections of your Committee resulted in awards to the following: *Senior High Division:* Paul E. Ingraham and Judith LaSalle, both of Cranston East High, and Barbara E. Marzocchi of Cumberland High. *Junior High Division:* Constance A. Barber of St. Margaret's, Rumford; Carole A. Jussaume of St. Charles Borromeo, West Warwick, and Andrea E. Toon of Lyman B. Goff, Pawtucket.

Each of these students will be presented the Society's honor award and a $25 U.S. Treasury bond at the Sesquicentennial Meeting Session at the Marvel Gymnasium on Wednesday, May 9, 1962.

Respectfully submitted,
JOHN F. W. GILMAN, M.D., *Chairman*
LELAND W. JONES, M.D.
CHARLES YORK, M.D.

SOCIAL WELFARE

At the request of the House of Delegates of the Rhode Island Medical Society, the Committee held an exploratory session regarding compensation for physicians for inpatient medical care for welfare patients. Considerable discussion showed there is a feeling among the committee members that care of welfare patients can be further strengthened and more closely co-ordinated with the private physician.

Accordingly the members voted to request the House of Delegates of the Rhode Island Medical Society to authorize the Social Welfare Committee to do the following: To study and explore in detail the existing program for welfare patients in Rhode Island including inpatient hospital care, outpatient hospital care, and office-home care for the purpose of (1) determining the objectives of the welfare program based on community needs; (2) the realism of the organizational structure of the welfare department so that an effective program can be expected; (3) the present and future role of the physician in the welfare program, and possible methods of compensating physicians for the care of welfare patients in achieving these ends.

Respectfully submitted,
PETER L. MATHIEU, M.D., *Chairman*

WOMAN'S AUXILIARY

There has been one predominant feature of this Auxiliary year, that of co-operation. This has been evidenced particularly in our Medical Society. We appreciate the compliment of recognition they afford us. We hope they are equally pleased with our



Coca-Cola, too, is compatible with a well balanced diet. As a pure, wholesome drink, it provides a bit of quick energy ... brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE-MARK ®

humble efforts to assist them. The working forces of the Auxiliary have co-operated wholeheartedly with their officers and board members and with each other. The result has been harmonious achievement in all areas.

The Family Day, Dinner Dance, the Auxiliary 15th Anniversary Celebration and the Exposition of Health Progress were areas where co-operation paid large dividends in pleasurable accomplishment, cementing our objective to "promote friendly relations and mutual understanding among physicians' families" and (in the case of the dinner dance) raise the funds necessary to award two scholarships in nursing, two health career scholarships, and donations to the Benevolent Fund and the A.M.E.F. To the latter was added contributions received from the use of sympathy cards and monies realized from the sale of A.M.E.F. playing cards.

We have tried to be more efficient by establishing financial voucher and secretarial filing systems and by having material of interest and importance bound for posterity. The Constitution and By-laws have been up-dated and a new printing issued, a necrology file established and a complete new roster assembled.

WJAR-TV invited us to present a series of six programs titled *The World of Health*. Co-operation again was the keyword. Physicians and Auxiliary members participated in the series covering various fields which were well received and merited the written acclaim of the program manager and a request for a second series now in production.

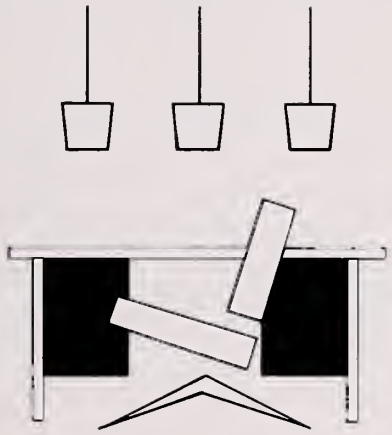
Legislation has been a tender topic in Rhode Island and as a unit the Auxiliary has avoided active participation in this field. As individuals, however, we have not been inactive but have upheld the policies of the Medical Society.

Doctor H. Frederick Stephens, representing the Ophthalmological Society, requested the support of the Auxiliary in forming a Rhode Island Chapter to the Society for the Prevention of Blindness. Members of the executive board held several meetings with Mrs. Ruby Hopkins, executive secretary of the Connecticut Society for the Prevention of Blindness and regional director of the National Society, and one meeting with Doctor Stephens attending. The recommended program was to establish preschool vision testing clinics throughout the state on a permanent schedule. It was ascertained to implement such a program would require the full time services of a co-ordinator over an extended period of time. At present such a time-consuming schedule is beyond our capabilities. Should an executive directed program be initiated, the Auxiliary will co-operate on a volunteer basis.

Volunteer assistance has been provided on state and local levels to the Diabetic Detection Clinics held throughout the state. Auxiliary representatives have attended all meetings of the Council of Community Services, Legislative Council, Civil Defense, Highway Safety Council and Governor's Safety Council. To better acquaint ourselves with the facilities available to the citizens of Rhode Island visits were made to Woonsocket Hospital and the Ladd School. All requests from national and the medical society have been complied with. Activities and programs have provided active participation in all fields of endeavor supported by the Auxiliary.

concluded on page 332

Attractive & Functional Offices
by BENÉ & CO., INC.



Designers & Suppliers of Offices
150 Dorrance Street • Providence 3, R. I. • GAspee 1-5228

FOR SALE --- $400 complete

PROFEXRAY— combination fluoroscope and X-ray machine. New tube never been used, In good condition. 20 ma. This price includes the machine, wall bracket for chest plates, tank for developing, lead apron and lead gloves, and all miscellaneous equipment, but not cost of moving. May be seen at Dr. M. J. O'Brien, 40 Elam St., N. Kingstown, CYpress 4-3831.

DISTRICT MEDICAL SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

A dinner meeting of the Newport County Medical Society and the medical officers from the Newport Naval Hospital was held at the Officers Club on April 11, 1962.

Norman Welch, M.D., speaker of the House of Delegates of the American Medical Association and also president of the Massachusetts Blue Shield, spoke on *Current Legislation and Its Effect on the Future of Medical Practice.*

Doctor Welch reviewed the background of the American Medical Association and the origins and development of Blue Cross and Blue Shield. He also discussed the Kerr-Mills bill and the King-Anderson bill. He pointed out that it was unnecessary to use taxes to support those people who do not need financial help. He further emphasized that the cost of financing and implementing the King-Anderson bill would far exceed the estimates of its proponents. A question and answer period followed Doctor Welch's speech.

Seated at the head table in addition to Doctor Welch were Donald B. Fletcher, M.D., president of the Newport County Medical Society; Charles A. Serbst, vice president of the society; Admiral J. S. Dorsey, Naval Base Commander; Samuel Adelson, M.D., president of the Rhode Island Medical Society; Capt. Jesse H. Suitor, Executive Officer of the Naval Hospital; Capt. Joseph L. Yon, Naval Hospital Commander, and José M. Ramos, M.D., past president of the Newport County Medical Society.

RICHARD R. KNOWLES, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A MEETING of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, February 5, 1962. The meeting was called to order by the president, Doctor J. Merrill Gibson, at 8:35 P.M.

The president announced that the minutes of the January meeting would not be read unless there was a request for a reading as they would be published in the RHODE ISLAND MEDICAL JOURNAL.

Report of the President

Doctor Gibson reported on the meeting held by the Association with members of the General Assembly from the Greater Providence area at which legislation before the legislature was discussed. He reported that a public hearing was to be held on the proposal that the board of directors of Physicians Service be a majority of non-physicians, and he urged members of the Association to attend the hearing.

Presentation of Membership Certificates

Certificates of membership were awarded by Doctor Gibson to the members elected at the annual meeting in January.

Scientific Program

The president introduced Doctor Robert Fleming, neuropsychiatrist at New England Deaconess Hospital, consultant at Peter Bent Brigham Hospital, member of the committee on Alcoholism of the American Medical Association, and vice chairman of a similar committee of the World Health Organization. Doctor Fleming discussed *Medical Dynamics of Alcoholism.*

Alcohol is a tissue depressant and depending somewhat on the individual the following blood alcohol levels produce these effects: 100 mg.%, subjective symptoms. 200 mg.% produces objective symptoms. At 300 mg.% one is still conscious but is helpless. 400 mg.% produces coma and 500 mg.% is lethal.

Chronic alcoholism can produce any one of four serious neuropsychiatric conditions. Delerium tremens or D T's is the most serious characterized by confusion, visual hallucinations, and a mood of fear. It is not necessary to have alcohol in the blood. Acute alcoholic hallucinosis is less serious than D T's, memory is intact, auditory hallucinations are very real and usually of a threatening nature. Korsakov's syndrome is characterized by failure of recent memory and confabulation. Prognosis for recovery very poor. Polyneuritis due to dietary lack of B_1 is easily reversible.

The incidence of chronic alcoholism is not known but if it is statistically related to cirrhosis of the liver there are 6,000,000 chronic alcoholics in the United States.

Drinkers are usually classified as symptomatic and addictive. The symptomatic drinker does so for many reasons. Drinking for relief of pain is com-

continued on page 330

skeletal muscle spasm is

tractable

with *Trancopal*®

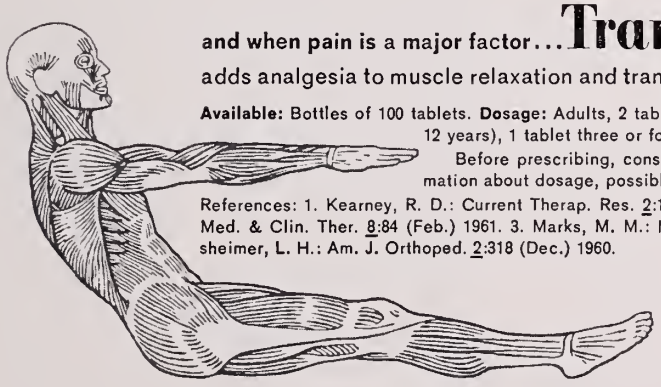
brand of chlormezanone

Low back pain and other skeletal muscle spasms are tractable disorders when you treat them with Trancopal, the relaxant that quickly eases the spasm and gets the muscle moving. You have a more tractable patient with Trancopal, too —its mild tranquilizing action makes him less irritable, better able to bear his discomfort, more willing to cooperate in physiotherapy.

These two complementary actions of Trancopal are commented on in many recent reports; e.g., Kearney[1] states: "...Trancopal has proven to be an extremely effective striated muscle relaxant and subcortical tranquilizer." Cornbleet,[2] discussing the use of Trancopal in dermatologic practice, comments: "Noteworthy was the soothing effect of chlormezanone without interference with normal activities or alertness... Patients were found more tractable and easier to control."

Marks[3] found that in patients with backache "...Trancopal offered considerable relief by alleviating both apprehension as well as musculoskeletal discomfort." Hergesheimer[4] comments: "...Trancopal acts to reduce the initial painful spasm and to allay anxiety, resulting in a cooperative patient whose subsequent recovery and return to work is accomplished more quickly."

Available: 200 mg. Caplets® (green colored, scored), 100 mg. Caplets (peach colored, scored), each in bottles of 100. **Dosage:** Adults, 200 mg. three or four times daily; children (5 to 12 years), from 50 to 100 mg. three or four times daily.



and when pain is a major factor... ***Trancoprin***® ASPIRIN (5 GRAINS) 300 MG. TRANCOPAL ..... 50 MG.

adds analgesia to muscle relaxation and tranquilization

Available: Bottles of 100 tablets. **Dosage:** Adults, 2 tablets three or four times daily; children (5 to 12 years), 1 tablet three or four times daily.

Before prescribing, consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

References: 1. Kearney, R. D.: Current Therap. Res. 2:127 (April) 1960. 2. Cornbleet, T.: Antibiotic Med. & Clin. Ther. 8:84 (Feb.) 1961. 3. Marks, M. M.: Missouri Med. 58:1037 (Oct.) 1961. 4. Hergesheimer, L. H.: Am. J. Orthoped. 2:318 (Dec.) 1960.

Winthrop LABORATORIES
New York 18, N. Y.

1696M

PROVIDENCE MEDICAL ASSOCIATION

continued from page 328

mon. Alcohol relieves anxiety. Social drinking for conviviality coupled with cultural factors can lead to heavy drinking. Some, called hedonistic drinkers, drink "just for the hell of it."

As a rule nothing much happens unless drinking continues over a long time. It may lead to physical symptoms such as gastritis, loss of appetite, and tremor. Personality changes may occur which lead to job trouble and wife trouble. Alcohol causes relief of symptoms and this vicious cycle may lead to true addictive drinking.

Doctor Fleming made three generalizations about addictive drinking:

1. It can happen to anyone if he drinks enough. The length of time required before one gets into trouble varies with the individual.

2. Once you get caught the only solution is total abstinence.

3. The most difficult cases are those who become addicted at a young age.

The treatment of alcoholics Doctor Fleming finds very rewarding. Initially the medical aspects are most important and a patient should be in a general hospital. Antabuse can be very helpful in selected cases but its use must be known to the patient and its effects very carefully explained. Alcoholics Anonymous has been very helpful and very successful.

Adjournment

The meeting adjourned at 10:25 P.M.

Collation was served.

Attendance was 64.

* * *

A meeting of the Providence Medical Association was held at the Library of the Rhode Island Medical Society on Monday, March 5, 1962. The meeting was called to order by the president, Doctor J. Merrill Gibson, at 8:40 P.M.

It was moved that the reading of the minutes of the previous meeting of the Association be omitted. The motion was seconded and passed.

Report of the Secretary

Doctor William A. Reid, secretary, reported as follows:

At a recent meeting the Executive Committee reviewed and approved the annual financial report of the Medical Milk Commission.

It also authorized the executive secretary to print a pamphlet approved by the Committee relative to Association activities for free distribution at the Health Fair at the Cranston Street Armory on April 6-14.

The Committee voted in the name of the Association to support a legislative amendment calling for improved minimum housing standards in Providence.

The Committee voted approval of a proposal for a preschool vision screening test for children in the 3- to 5-year age range, on the condition that the referrals for necessary treatment be to ophthalmologists or hospital clinics under the supervision of ophthalmologists.

The Committee noted that the civil defense Medical Self-Help program is to be discussed at the March 5th meeting of the Association and it expressed its hope that the members of the Association will give this program full support.

Approval was given the plan of the Committee on Entertainment for the annual dinner and golf tournament of the Association to be held at the Agawam Hunt Club in Rumford on Wednesday, June 20, 1962.

Nominations for Membership

The secretary reported that the Executive Committee has reviewed the applications for active membership in the Association of the following physicians, and it has approved of their nomination for election: Gabriel A. Najera, M.D., and Josiah Sacks, M.D.

The motion was made, seconded and passed that these physicians be elected to active membership.

Announcement by the President

Doctor Gibson called attention to the Cancer Conference for Rhode Island physicians to be held in the Auditorium of the Rhode Island Medical Society on Wednesday, March 28. The program is a panel discussion on *Carcinoma of the Colon and Rectum*. The program will be from 2 P.M. until 5 P.M., and he urged all members to attend.

Scientific Program

Doctor Gibson and Doctor Francis E. Hanley, chairman of the Disaster Committee of the Rhode Island Medical Society, discussed *The Medical Self-Help Program for Professional Health, Civil Defense and Education Personnel.*

Mr. Austin C. Daley, director of the Division of Minimum Housing Standards of the City of Providence, discussed *Providence Minimum Housing Standards* and showed colored lantern slides of before and after effects in the improvement of housing in various sections of greater Providence.

The meeting adjourned at 10:15 P.M.

Attendance was 48.

Collation was served.

* * *

A regular meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, April 2, 1962. The meeting was called to order by the president, Doctor J. Merrill Gibson, at 8:30 P.M.

The reading of the minutes of the March meeting was omitted.

Report of the Secretary

Doctor William A. Reid, secretary, reported as follows:

At a recent meeting the Executive Committee took the following actions:

1. It approved of a special mailing to the membership relative to physicians to answer emergency calls for a physician directed to our Medical Bureau.

2. It approved of a special loop from the Bureau to the Cranston Street Armory for the Health Fair to enable members subscribing to the Bureau to be reached promptly, and it approved of a separate line for non-members of the Bureau.

3. It approved of a special flier to be distributed at the Association's exhibit at the Health Fair reporting on the activities of doctors of medicine in Rhode Island in the interest of the public's health.

4. It voted to submit the following resolution to the Association at the April 2nd meeting:

WHEREAS the Providence Medical Association is most anxious that every citizen in Rhode Island be immunized for protection against infectious diseases, and

WHEREAS there are now available effective vaccines for the prevention of poliomyelitis,

THEREFORE the Association again urges every citizen to seek such immunization through the services of his local Health Departments at the clinics they will conduct for those not seeking private medical care.

ACTION: It was moved that the report of the secretary and the adoption of the resolution included in the report be approved. The motion was seconded and passed.

Announcements of the President

Doctor J. Merrill Gibson urged the members to support the Rhode Island Medical Society's Exposition of Health Progress to be held from April 7-14 and to attend the preview with their families the evening of Friday, April 6. He also urged any members who have not paid the special assessment to make possible the health exposition to do so promptly.

He also reported on plans for the Sesquicentennial scientific assembly of the state medical society to be held May 8 and 9.

He reported that the Annual Dinner and Golf Tournament of the Providence Medical Association is to be held at the Agawam Hunt Club on Wednesday, June 20.

Election of New Members

Doctor William A. Reid, secretary, reported that the Executive Committee recommended for election to active membership the following physicians: Mary P. Colbert, M.D.; Richard D. Frary, M.D.; Theodore K. Gibson, M.D.; Gian-Fortunat Hoessly, M.D.; Richard K. Mead, M.D.; Moctezuma S. Urista, M.D., and Paul T. Welch, M.D.

ACTION: It was moved that the applicants recommended be elected. The motion was seconded and passed.

Scientific Program

Doctor Gibson introduced Doctor Elihu Saklad, chief of the Department of Anesthesiology at Rhode Island Hospital, who with Doctor William C. Howrie, senior assistant, Department of Anesthesiology, Rhode Island Hospital, and Doctor Augustine M. McNamee, assistant, Department of Anesthesiology, Rhode Island Hospital, presented a panel discussion on *How Some Commonly Used Drugs Become Surgical Hazards.* (Doctor Saklad and his associates will summarize their lectures and report them in the RHODE ISLAND MEDICAL JOURNAL.)

Doctor Gibson introduced Doctor Charles L. Farrell, member of the Medical Advisory Committee to the Department of Health, Education and Welfare, who discussed the disability provision of the Social Security Act relative to disabled workers prior to showing of a motion picture in color and sound titled *The Disability Decision.*

The meeting was adjourned at 10:30 P.M.

Attendance was 76.

Collation was served.

Respectfully submitted,

WILLIAM A. REID, M.D., *Secretary*

Curran & Burton, Inc.

INDUSTRIAL
AND WHOLESALE

COAL **OIL**

17 CUSTOM HOUSE STREET
PROVIDENCE, R. I.
DExter 1-3315

PATRONIZE
JOURNAL ADVERTISERS

GENERAL MEETING, R. I. MEDICAL SOCIETY

concluded from page 307

Doctor Charles L. Farrell moved that the resolution be referred to the House of Delegates. The motion was seconded.

Doctor Adelson noted that a motion to refer is not debatable, and he called for a vote. The motion to refer the resolution to the House of Delegates was adopted.

New Officers

The president named Doctors Edmund T. Hackman and Peter Erinakes of Warwick to escort Doctor Arthur E. Hardy, the new president, to the rostrum. Doctor Hardy delivered a brief message of acceptance of the honor, and called upon the membership to continue to work in the best interests of the public and the profession.

Adjournment

The general meeting was adjourned at 1:00 P.M.

Respectfully submitted,

MICHAEL DIMAIO, M.D., *Secretary*

Continuing Education Sought by 90% of Nation's Physicians

Responses to a questionnaire sent to physicians in private practice in the United States revealed that 90% had taken postgraduate or continuing medical education courses. Almost half of these physicians took courses last year, and an even greater percentage intend to take courses this year. The survey was conducted by *Patterns of Disease*, a monthly Parke, Davis & Company publication for physicians.

In a report of the survey on continuing medical education, *Patterns* noted that of those physicians who reported taking courses in 1961, 50% were specialists, 38% in general practice, and 12% in part-time specialty practice. In selecting the types of courses they preferred, 58% cited lecture courses, 50% seminars, 42% clinic courses and only 7% laboratory courses.

"Busy physicians apparently prefer not to take too much time from their practices," *Patterns* reported, "more than 90% indicated that they favor courses lasting one week or less. Lectures and seminars are the types of courses seemingly preferred by the physicians."

"One third of physicians who reported they had been students in courses in 1961 were graduated from medical school within the last 10 years," *Patterns* said. "An equal proportion had been graduated in the period 1941-1950, and almost 10% had been graduated more than 30 years ago."

HOUSE OF DELEGATES

concluded from page 327

Sincere appreciation for the co-operation of Doctor Samuel Adelson; our advisers, Doctors Henri Gauthier, John A. Dillon, Earl F. Kelly and Alfred L. Potter; for the assistance of the Library staff, Mrs. Helen DeJong, Miss Annmarie Savone, Miss Nancy K. Heinkel, and Miss Deborah Clarke; particularly for the patient, kind and wise counsel of Mr. John E. Farrell, and for the financial aid afforded us by the Medical Society, is gratefully and humbly offered.

It has been my pleasure to serve as president of the Woman's Auxiliary to the Rhode Island Medical Society.

Respectfully submitted,

MRS. JAMES P. O'BRIEN, *President*

INDEX OF ADVERTISERS

	PAGE
Air Ambulance Service	321
E. A. Anthony	304
Bene & Co.	327
J. E. Brennan	304
Burroughs Wellcome	290
Coca-Cola	326
Curran & Burton	331
Derosier Agency	284
Duff-Mott Company	285
Fuller Memorial Sanitorium	284
Health Havens	324
Lederle Laboratories	287, 291, 295, 323
Eli Lilly & Co.	Front Cover
Medical Bureau	282
Medical Milk Commission	293
Munroe Dairy	325
Parke, Davis & Company	Inside Front Cover, 281
Physicians Service	Back Cover
R. I. Hospital Trust	282
Sealy Mattress	Third Cover
G. D. Searle	296
Smith, Kline & French Laboratories	319
E. R. Squibb	289
U. S. Vitamin	316-317
Warwick Club Beverages	320
Winthrop Laboratories	313, 329

The extra-firm mattress selected by over 9,000 doctors for their own use

Assures both preventive and corrective support—used in more American homes than any other special design

Sealy Posturepedic is the first mattress designed in cooperation with leading orthopedic surgeons to promote normal, healthful sleep among *all* persons.

As a "corrective device" it serves those chronically afflicted with lower back syndromes. As a preventive measure Sealy Posturepedic brings deep spring buoyancy without bedboard hardness to everyone—plus the concomitant blessings of unexcelled comfort and extra-firm support.

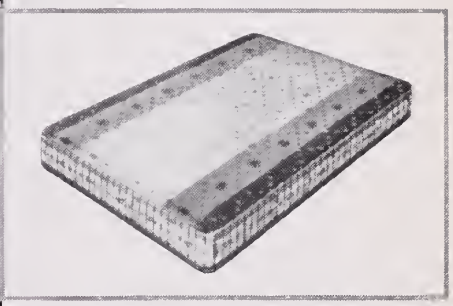
These are basic to good health. The therapeutic value of restful sleep is especially recognized during these tense and anxious days. Sealy Posturepedic eminently meets this need by supplying level spine support for proper relaxation of the limbs and human musculatory system.

Over 9,000 doctors of medicine have tried and bought the Sealy Posturepedic mattress and matching foundation for their own use. We believe your investigation will firmly convince you of its distinctive benefits, and, we would hope, merit your valued recommendation.

Sealy POSTUREPEDIC® BRAND

NO MORNING BACKACHE
from a too-soft mattress





PROFESSIONAL DISCOUNT OF $39.00

So that you may judge the quality of the Sealy Posturepedic for yourself, we offer a special Professional Discount on this mattress and foundation when purchased for your personal use. *Limit—one full or two twin size sets.*

SEALY MATTRESS COMPANY • Oakville, Conn.

Enclosed is my check and letterhead. Please ship the Sealy Posturepedic Set(s) indicated below:

1 Full Size ☐ **1 Twin Size** ☐ **2 Twin Size** ☐

	RETAIL		PROFESSIONAL
Posturepedic Mattress	each $79.50	(add state tax)	$60.00
Posturepedic Foundation	each $79.50	(add state tax)	$60.00

NAME_____

RESIDENCE_____

CITY_____ ZONE_____ STATE_____

(This is a saving of $39.00 per set over the regular $159.00 retail price for mattress and matching foundation)

© Sealy, Inc., 1958

BRIEFS

FROM THE PHYSICIANS SERVICE PLAN
THE RHODE ISLAND MEDICAL SOCI

How often does a patient ask...

Which Surgical-Medical Plan Delivers the Most Value?

New Cost Analysis Gives the Facts!

The arithmetic of this survey is simple. It shows that your Physicians Service Plan pays the highest level of benefits for every subscriber's dollar because its cost of operation is about *one half* the national average for Blue Shield Plans. Here are the facts:

RHODE ISLAND	NATIONAL
18c	**35c**
cost per contract per month	*composite average cost per contract per month*

These figures are taken from the "Functional Cost Report", the initial report of a national comparative cost analysis just released by the Association of Blue Shield Plans.

This study shows that your Physicians Service has the lowest cost per contract per month of any of the 48 Blue Shield Plans participating in the program. It is additional evidence, based upon uniform cost accounting systems, of the low dollar cost, as well as low percentage cost of operating Physicians Service.

This record of efficiency means more money is returned in health care benefits . . . more returned to the physician, the patient, and the community.

31 CANAL ST., PROVIDENCE 1, RHODE ISLAND · PHONE: TEMPLE 1-7300

JULY, 1962

RHODE ISLAND

Medical Journal

THE NEW YORK ACADEMY OF MEDICINE
OCT 25 1962
LIBRARY

Volume XLV, No. 7

Table of Contents, page 335

a look at the literature



240285

"Treatment results were good, and in many cases a dramatic response was noted. Many of the cases had previously failed to respond to various types of therapy, including, in some instances, other topical corticosteroid preparations."

—Gray, H. R., Wolf, R. L., and Doneff, R. H.: Evaluation of Flurandrenolone, a New Topical Corticosteroid, Arch. Dermat., *84*:18, 1961.

Description: Each Gm. Cordran cream and ointment contains 0.5 mg. Cordran. Each Gm. Cordran™-N cream and ointment contains 0.5 mg. Cordran and 5 mg. neomycin sulfate.
All forms are supplied in 7.5 and 15-Gm. tubes.

Cordran™-N (flurandrenolone with neomycin sulfate, Lilly)

This is a reminder advertisement. For adequate information for use, please consult manufacturer's literature. Eli Lilly and Company, Indianapolis 6, Indiana.

Lilly

The incidence of postoperative wound infections, particularly among debilitated patients, presents a serious hospital problem.[1] These infections are caused in many cases by strains of staphylococci resistant to most antibiotics in common use.[1,2,3] In such instances, CHLOROMYCETIN should be considered, since "...the very great majority of the so-called resistant staphylococci are susceptible to its action."[4]

Staphylococcal resistance to CHLOROMYCETIN remains surprisingly infrequent, despite widespread use of the drug.[2,4,5-7] In one hospital, for example, even though consumption of CHLOROMYCETIN increased markedly since 1955, there was little change in the susceptibility of staphylococci to the drug.[7]

Characteristically wide in its antibacterial spectrum, CHLOROMYCETIN has also proved valuable in surgical infections caused by other pathogens—both gram-positive **and** gram-negative.[7,8]

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100.

See package insert for details of administration and dosage.

Warning: Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, granulocytopenia) are known to occur after the administration of chloramphenicol. Blood dyscrasias have occurred after both short-term and prolonged therapy with this drug. Bearing in mind the possibility that such reactions may occur, chloramphenicol should be used only for serious infections caused by organisms which are susceptible to its antibacterial effects. Chloramphenicol should not be used when other less potentially dangerous agents will be effective, or in the treatment of trivial infections such as colds, influenza, or viral infections of the throat, or as a prophylactic agent.

Precautions: It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

References: (1) Minchew, B. H., & Cluff, L. E.: *J. Chron. Dis.* **13**:354, 1961. (2) Wallmark, G., & Finland, M.: *Am. J. M. Sc.* **242**:279, 1961. (3) Wallmark, G., & Finland, M.: *J.A.M.A.* **175**:886, 1961. (4) Welch, H., in Welch, H., & Finland, M.: Antibiotic Therapy for Staphylococcal Diseases, New York, Medical Encyclopedia, Inc., 1959, p. 14. (5) Hodgman, J. E.: *Pediat. Clin. North America* **8**:1027, 1961. (6) Bauer, A. W.; Perry, D. M., & Kirby, W. M. M.: *J.A.M.A.* **173**:475, 1960. (7) Petersdorf, R. G., *et al.*: *Arch. Int. Med.* **105**:398, 1960. (8) Goodier, T. E. W., & Parry, W. R.: *Lancet* **1**:356, 1959.

PARKE-DAVIS

90262 PARKE, DAVIS & COMPANY, Detroit 32, Michigan



when postoperative infection complicates convalescence...

CHLOROMYCETIN®

(chloramphenicol, Parke-Davis)

for broad antibacterial action

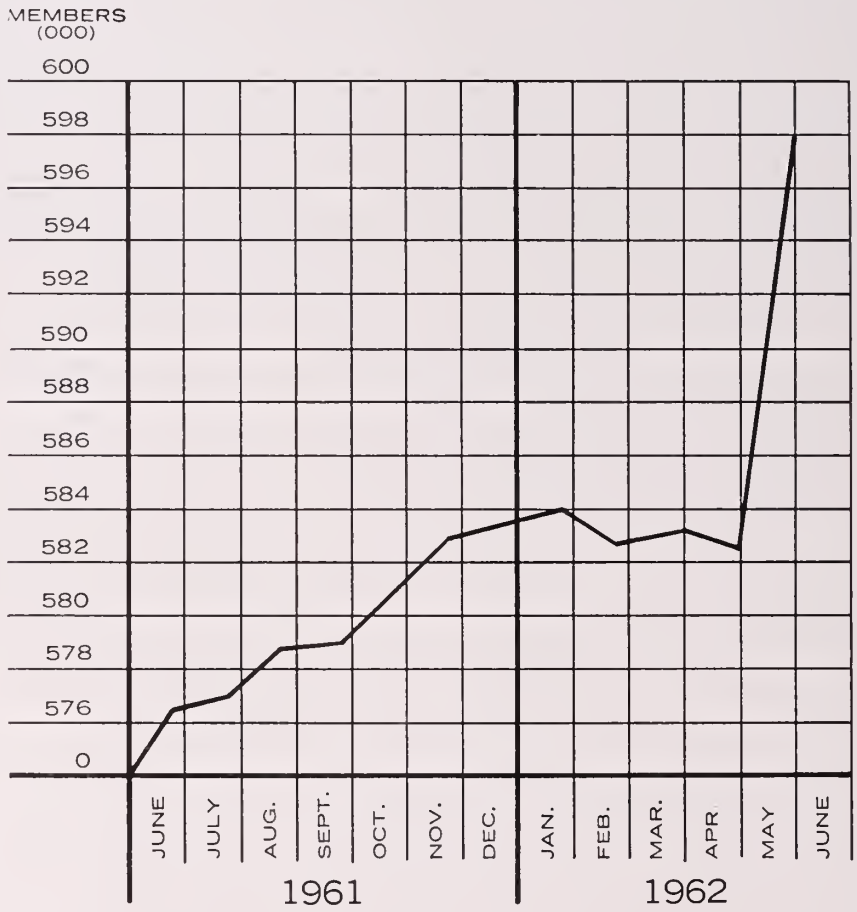


BRIEFS

FROM THE PHYSICIANS SERVICE PLAN OF
THE RHODE ISLAND MEDICAL SOCIETY

Physicians Service membership reaches all time high:

Nears 600,000 mark!



For the first time in the history of the Plan. Physicians Service membership neared the 600.000 mark — as the addition of members who joined during the recent open-enrollment drive was recorded.

As the graph shows. membership at the end of May. 1962 was almost 22.000 higher than the previous year. and increased abont 14.000 over the prior month.

Physicians Service continues to lead the nation in percentage of state-wide enrollment. with almost 70% of the eligible Rhode Island population enrolled.

The RHODE ISLAND MEDICAL JOURNAL

Editorial and Business Office: 106 Francis Street, Providence, R. I.

Editor-in-Chief: SEEBERT J. GOLDOWSKY, M.D.

Managing Editor: JOHN E. FARRELL, SC.D.

Senior Editors

ALEX M. BURGESS, SR., M.D. HENRI E. GAUTHIER, M.D.

Advisory Board

(in addition to editors listed above)

JOHN A. DILLON, M.D. JOHN F. W. GILMAN, M.D. ROBERT V. LEWIS, M.D.
PETER L. MATHIEU, M.D. JOSÉ M. RAMOS, M.D. ROBERT W. RIEMER, M.D.
JACK SAVRAN, M.D. LESTER L. VARGAS, M.D.

Owned and Published Monthly by
THE RHODE ISLAND MEDICAL SOCIETY
Second-class postage paid at Providence, Rhode Island
Copyright, 1962, the Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island
Single copies, 25 cents . . . Subscription, $2.00 per year.

Volume XLV, No. 7 July, 1962

TABLE OF CONTENTS

PAGE

CURRENT STATUS OF CARDIAC SURGERY, The Caleb Fiske Prize Essay, *Lester L. Vargas*, M.D. ... 349

ACUTE RENAL FAILURE COMPLICATING SALICYLATE INTOXICATION: ROLE OF THE ARTIFICIAL KIDNEY, A Case Report ... *John B. Lawlor*, M.D.; *Roger G. Berard*, M.D., AND *Ernest K. Landsteiner*, M.D. 366

PRIMARY ALDOSTERONISM, Report of a Case, *Daniel S. Liang*, M.D. ... 368

THE RESPONSIBILITY OF THE PHYSICIAN IN THE CERTIFICATION OF DEATH, A Review of the Rhode Island Statute ... 372

EDITORIALS

The Fiske Fund Prize Essay ... 363

Boating and Boating Hazards ... 363

Dear NIH: ... 364

Swimming Pools ... 365

DEPARTMENTS

Scanning the Medical Literature ... 338

Book Reviews ... 344

District Medical Society Meetings ... 378

Through the Microscope ... 382

Index of Advertisers ... 384

AN AMES CLINIQUICK®
CLINICAL BRIEFS FOR MODERN PRACTICE

WHY TEST URINE ROUTINELY FOR PROTEIN ?

In a recent series of 278 diabetic patients, 34.2 per cent (95) had proteinuria. Of this group, almost 3 out of 5 had previously unrecognized renal disease, usually asymptomatic and untreated.[1] Proteinuria may give valuable warning not only of infectious and other renal disorders, but also of degenerative diabetic nephropathy.[2]

With URISTIX Reagent Strips, testing for proteinuria *and* glucosuria may be conveniently done at the same time. URISTIX is "... reliable for routine clinical use."[1] It will not give false-positive protein reactions with oral hypoglycemic agent metabolites. URISTIX is simple for patients to use at home and is timesaving for technicians.[1]

References: (1) Moss, J. M.; Schreiner, G. E., and Sweeney, V.: M. Times *89*:12 (Jan.) 1961. (2) El Mahallawy, M., and Sabour, M. S.: J.A.M.A. *173*:1783 (Aug. 20) 1960.

for broader day-to-day protection of the diabetic patient

DIP AND READ

uristix®

urine protein • glucose

AMES COMPANY, INC
Elkhart • Indiana
Toronto • Canada

1 dip . . . 10 seconds . . . 2 readings

available: URISTIX Reagent Strips, bottles of 125

20062

consider
the convenience
to pregnant
women of
a tablet this size



ENGRAN

Squibb Vitamin-Mineral Prenatal Supplement

FORMULA SUPPLIES 45 MG. OF IRON – AT NO EXTRA COST

The size of a prenatal vitamin-supplement tablet is important—the nausea and gastric distress often associated with pregnancy may make swallowing *anything* a real problem. Hence the small size of the Engran tablet is a great convenience to your pregnant patient, for Engran is actually the *smallest* tablet now available for prenatal vitamin-mineral supplementation. Yet only *one Engran tablet* a day will provide all these vitamins and minerals to help assure a nutritionally perfect pregnancy –

Vitamin A 5,000 U.S.P. units; vitamin D 500 U.S.P. units; thiamine 3 mg.; riboflavin 3 mg.; pyridoxine 2 mg.; vitamin B_{12} 2 mcg.; niacinamide 20 mg.; calcium pantothenate 5 mg.; vitamin C 75 mg.; calcium 100 mg.; iron 45 mg.; iodine 0.15 mg.; copper 1 mg.; magnesium 6 mg.; zinc 1.5 mg.; manganese 1 mg.

For full information see your Squibb Product Reference or Product Brief.

SQUIBB *Squibb Quality—the Priceless Ingredient*

SQUIBB DIVISION Olin

Engran® is a Squibb trademark

SCANNING THE MEDICAL LITERATURE

DIAGNOSIS AND SURGICAL TREATMENT OF ARTERIOSCLEROTIC AORTO-ILIAC OCCLUSION. Lester L. Vargas. Clinical Med. 8:37, 1961.

Arteriosclerotic occlusion of the distal aorta, also known as Leriche's syndrome, is a progressive incapacitating disease which, in most cases, is surgically remediable. It is characterized by the development of atherosclerosis at the origins of the iliac vessels immediately at the aortic bifurcation. Thrombosis follows with occlusion of the terminal aorta and the proximal iliac vessels.

The clinical manifestations of the disease are characteristic and are reviewed in detail in the article. The diagnosis can readily be made by physical examination and can be confirmed by the use of aortography.

Methods for restoring vascular continuity are as follows:

1. Resection of the diseased aorta and its branches with replacement by a suitable vascular graft.
2. By-pass of the occluded vessels with a blood vessel graft.
3. Excision of the diseased intima and occluding thrombotic material by thrombo-endarterectomy.

OCCLUDING THROMBI OF THE LEFT ATRIUM. Report of Four Cases Treated Surgically. Lester L. Vargas and William P. Corvese. Dis. Chest 40:313, 1961.

Among the morphologic variants of left atrial thrombi, the unattached ball or pedunculated thrombus poses the greatest problem in surgical management and judgment. Attention was called to the fact that large occluding thrombi require an open technique for their safe removal. On the other hand, a number of intermediate-sized thrombi can be treated surgically by less elaborate means when encountered unexpectedly.

Four clinical cases encountered among 105 operations for the relief of mitral stenosis at the Rhode Island Hospital were presented to illustrate the problem in diagnosis and surgical management.

The surgical technique employed in three patients in whom free-floating intra-atrial thrombi were encountered unexpectedly was chosen in an effort to avoid fragmenting the thrombus. It took advantage of a tight mitral stenosis which effectively restricted the thrombus to the atrium and created an elevated atrial pressure sufficient to expel the thrombus through an enlarged but suture-controlled atriotomy. A fourth patient was suspected of having an occluding thrombus and underwent an open operation.

MONOAMNIOTIC TWIN PREGNANCY. A Review of the Literature and a Report of 5 New Cases. Sumner I. Raphael. Am. J. Obst. & Gynec. 81:323, 1961.

The purpose of this paper was to review the literature, to point out the increased danger to the fetuses and to report five additional cases of monoamniotic twin pregnancies with three double survivals which had occurred at the P.L.I.H. during the eleven-year period 1949 to 1959.

History was discussed and it was pointed out that the incidence in the literature ranges from 1 to 1,000 all the way up to 1 to 93,000 deliveries. The Lying-In Hospital incidence was 1 to 16,000 deliveries or one set of monoamniotic twins to every 165 sets of twins. The true incidence cannot be accurately calculated unless obstetricians observe all twin deliveries with this possibility in mind and report all cases.

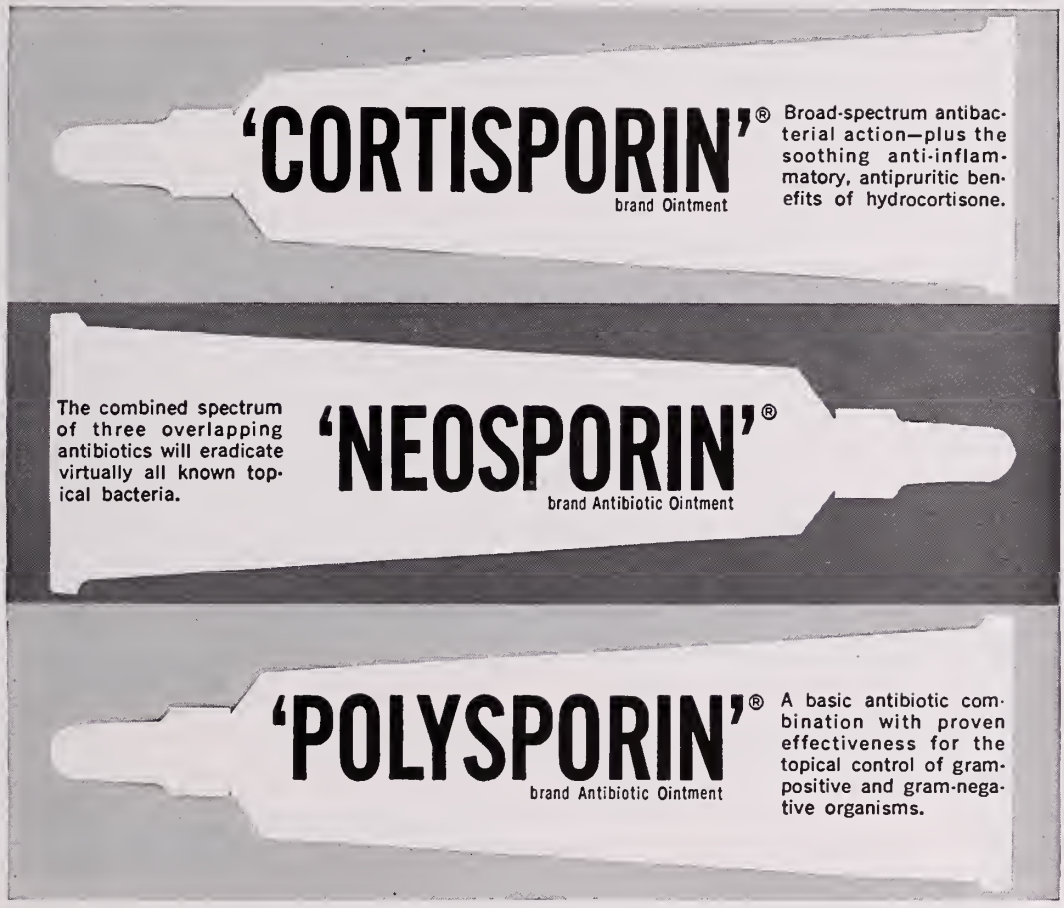
This entity is due to late division of the embryonic area which occurs after the amnion has begun to form, then both twins are enclosed in a common amnion as well as in a common chorion. The clinical significance is that whereas multiple births are ordinarily associated with a three to four times increased risk of stillbirth and neonatal death, in this condition the hazard is even greater due to the interference with the fetal circulation coincident to the twisting and knotting of the umbilical cords.

This is borne out by the reported statistics which demonstrate that although there is little or no danger to the mother, the risk to the fetus is great. Of 183 total cases in the literature included in this report there were only 51 cases of survival of both infants.

There is no way to diagnose this condition prior to delivery. At the time of delivery the diagnosis is made by noting the absence of a second amniotic

concluded on page 340

'B. W. & Co.' 'Sporin' Ointments rarely sensitize . . . give decisive bactericidal action for most every topical indication



Contents per Gm.	'Polysporin'®	'Neosporin'®	'Cortisporin'®
'Aerosporin'® brand Polymyxin B Sulfate	10,000 Units	5,000 Units	5,000 Units
Zinc Bacitracin	500 Units	400 Units	400 Units
Neomycin Sulfate	—	5 mg.	5 mg.
Hydrocortisone	—	—	10 mg.
Supplied:	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of ½ oz. and ⅛ oz. (with ophthalmic tip)

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

SCANNING THE MEDICAL LITERATURE

concluded from page 338

sac and, in some cases, the twisting and knotting of the umbilical cords.

At a time when obstetricians are concerned with perinatal mortality more than ever before it is important that they be aware of this entity so that during each twin delivery in the absence of a second amniotic sac or when the umbilical cords are intertwined they will hasten to deliver the second twin.

The improvement in double survival rates for monoamniotic twins since Quigley's original figure of 16 per cent in 1935 to the present study which reveals a 46 per cent double survival rate is a reflection of the better facilities for delivery and the more skillful obstetrical care existing at the present time.

COMBINED ENCEPHALOPATHY AND NEUROPATHY WITH CARCINOMA. Harold W. Williams. J. Neuropath. & Exper. Neurol. 20:535, 1961.

Primary multifocal leukodystrophy is a distinctive sudanophilic type of demyelinization of brain which has been identified in settings of lymphatic leukemia, Hodgkin's disease and exceptionally in sarcoidosis and tuberculosis. This type of demyelinization was identified by us for the first time in an instance of carcinoma which had been carefully studied neurologically because of a concomitant neuropathy. Now available in the literature is an account of the status of spinal cord and peripheral nerves in this type of demyelinization. We postulated an antimetabolite, the consequence of the primary pathology, had significance in the appearance of primary multifocal leukodystrophy. Others consider the alteration and occlusion bodies in the oligodendroglia, a type of glia having responsibility for myelization, indicate a complicating virus infection. Further study of this disorder may yield additional understanding about demyelinating diseases in general and the pathophysiological processes which attend the presence of Hodgkin's disease, lymphatic leukemia and cancer. Visual disturbances in terms of field defects and disturbances in mentation may be clues leading to the diagnosis of this type of demyelinating disease.

POLYPOID ADENOMAS OF THE STOMACH. Thomas Perry, Jr. and Khalil Shekarchi. Am.J.Surg. 101:440, 1961.

This paper describes the Rhode Island Hospital experience with stomach polyps during the past twenty years. The twenty-three cases fell into two groups, twelve with one or two polyps, and eleven with numerous polyps. One of the latter was a case of Peutz-Jeghers syndrome of intestinal polyposis with stomach involvement.

Two of the multiple polyposis cases and two of the isolated polyps were malignant. As might be expected, these polypoid cancers are slow to spread locally and to metastasize, and the outlook is favorable. For this reason, in multiple polyposis, with or without a malignant polyp, partial rather than total gastrectomy is favored.

As has been noted elsewhere, it was found in this study that polyps under 2 cm. are rarely malignant. Such polyps in poor surgical risk patients may be observed with barium studies at six months intervals. If the polyp or polyps are not enlarging, they may be left alone. Large polyps should be removed whenever possible. Four of the six polyps over 2 cm. in diameter in this series were malignant while all under 2 cm. were benign.



Fuller

Memorial Sanitarium

Located on Rt. 1

South Attleboro, Massachusetts

A modern non-profit hospital for the care and treatment of nervous and emotional disorders as well as long term geriatric problems.

Physical, neurological, psychiatric and psychological examinations.

Modern recognized psychiatric therapies.

A pleasant homelike atmosphere in a beautiful and conveniently located institution.

L. A. Senseman, M.D., F.A.P.A., Medical Director
Edwin Dunlop, M.D. Michael G. Touloumtzis, M.A.
Oliver S. Lindberg, M.D. William H. Dunn, M.S.W.
W. H. Lesovsky, M.D., Ph.D.

Referred patients are seen daily (except Saturdays) 9-12 A.M., and by appointment.
R. I. Blue Cross Benefits Tel. Southgate 1-8500

Special Rates for Long-Term Care

PAINFUL DENTISTRY

The Providence *Evening Bulletin* published the following news item on June 26:

"London — (UPI) — Britain's government-employed dentists will have to take a 5.9 per cent cut in average pay starting July 2.

"The Ministry of Health said the new average salary would be $7,000 a year, compared with $7,686 in 1961.

"Under Britain's socialized medicine, the country's dentists receive a token fee from patients and the balance from the government."



PERCODAN BRINGS *SPEED*...DURATION... AND DEPTH TO ORAL ANALGESIA

in the wide middle region of pain

PERCODAN®

(Salts of Dihydrohydroxycodeinone and Homatropine, plus APC) TABLETS

fills the gap between mild oral and potent parenteral analgesics

■ acts in 5-15 minutes ■ relief usually lasts 6 hours or longer ■ constipation rare ■ sleep uninterrupted by pain

Literature on request

Endo®

ENDO LABORATORIES
Richmond Hill 18, New York

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Federal law allows oral prescription. *Also Available:* Percodan®-Demi: the complete Percodan formula, but with only half the amount of salts of dihydrohydroxycodeinone and homatropine.

Each scored, yellow Percodan* Tablet contains 4.50 mg. dihydrohydroxycodeinone HCl, 0.38 mg. dihydrohydroxycodeinone terephthalate (warning: may be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. acetophenetidin, and 32 mg. caffeine.

*U.S. Pats. 2,628,185 and 2,907,768

Certified MILK

THE AMERICAN ASSOCIATION OF MEDICAL MILK COMMISSIONS SUPERVISES THE PRODUCTION OF

Certified MILK



1. CLEANER. Lowest bacteria-count. Milk checked before each milking. All utensils, bottles, and equipment sterilized before use.

2. BETTER-PROTECTED. Strictest medical supervision of herds and employees. Frequent examinations and laboratory-control AT THE FARM are required.

3. AUTOMATIC MILKING. Cows are milked automatically by electric machine. Milk is bottled without exposure to air or human touch.

4. BOTTLE CLOSURES. Must be of the highest quality to provide complete protection for the milk and bear approval of The American Association of Medical Milk Commissions.

5. MORE NUTRITIOUS. Cows scientifically fed balanced ration. Nutrition control from soil to delivery of milk. Same diet all year.

6. LONGER-LASTING, BETTER-TASTING. Diet control, special handling, and shortest time of delivery from cow to consumer assure fine fresh flavor that lasts for weeks.

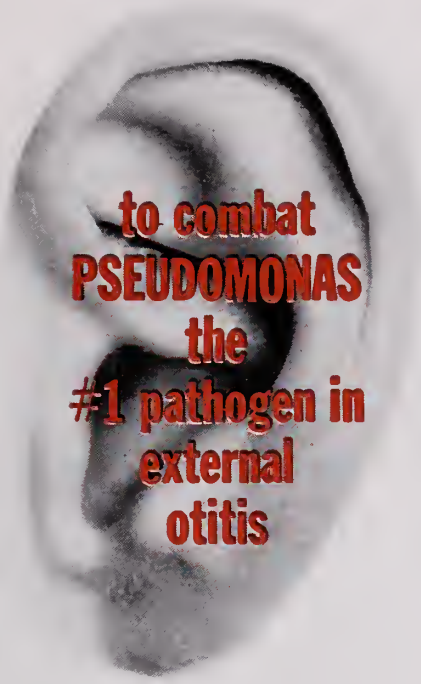
7. THE DOCTOR'S MILK. Produced, processed, bottled on farms supervised by Medical Milk Commissions. Each bottle bears the seal of the A.A.M.M.C. and names of the supervising Commission and producing farm.

MILK COMMISSION OF PROVIDENCE MEDICAL ASSOCIATION

HILLSIDE FARMS, INC., 1308 Phenix Ave., Cranston, WI 2-3400
Produced at Hillside Farm, Cranston, R. I.

H. P. HOOD & SONS, 135 Harris Ave., Providence, DE 1-3024
Produced at Hood Certified Farm, Beverly, Mass.

WHITING MILK CO., 40 Tockwotton St., Providence, GA 1-5363
Produced at Hampshire Hills Farm, Wilton, N. H.



'CORTISPORIN'®

OTIC DROPS (sterile) brand

the #1 therapy for inflamed, infected ears

Because it provides Polymyxin B for the eradication of Pseudomonas, the prime cause of external otitis, 'Cortisporin' is the logical choice of treatment for inflamed, infected ears. Polymyxin B is the antibiotic specific for *Pseudomonas aeruginosa* infections, and is, for this pathogen, the standard of effectiveness against which other antibacterials are measured.

- Anti-inflammatory
- Antipruritic
- Antibacterial



Each cc. contains:

'Aerosporin'® brand Polymyxin B sulfate	10,000 units
Neomycin Sulfate	5 mg.
(Equivalent to 3.5 mg. Neomycin Base)	
Hydrocortisone	10 mg. (1%)

Bottles of 5 cc. with sterile dropper.

Literature available on request.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

BOOK REVIEWS

THE DYNASTY. A Medical Novel by Charles H. Knickerbocker. Doubleday & Co., Inc., Garden City, N.Y., 1962. $4.50

Do you enjoy reading novels that display a well-balanced amount of tension and conflict? If so, may I suggest that you read this one. Here is a book that deals with a family of doctors and of a young physician's struggle to maintain his high ideals. John Crest, however, does, even though married to the daughter of a doctor whose judgment he questions. The book goes on to show how he combats the influence of his domineering father-in-law to establish a practice of his own, thus becoming the doctor of his dreams — well-liked and competent.

ANNMARIE SAVONE

TOMORROW'S MIRACLE by Frank G. Slaughter, M.D. Doubleday & Co., Inc., Garden City, New York, 1962. $3.95

This is another of Doctor Slaughter's many books written to sell to unthinking and unrealistic readers who like the "Pollyanna" type of literature, although he does yield to modern demand by introducing an element of sex. The book is so incredible and full of "sweetness and light" that it was completely boring to this reviewer.

All the medical incidents seem to be authentic. It is the story of a dedicated young doctor who, by earning money as an evangelist, finally becomes a medical missionary. He gives up his true love to marry an infatuated young woman in order to save her life. Several years after his wife's death, he receives his reward when his first love survives an airplane accident near the mission hospital in Africa. Her insane husband dies.

If you like this type of book, you'll enjoy this one. I just don't.

AMY E. RUSSELL, M.D.

THE CARDIAC ARRHYTHMIAS. A Guide for the General Practitioner by Brendan Phibbs, M.D. The C. V. Mosby Co., St. Louis, 1961. $7.50

"The patient . . . is dyspneic and cyanotic, with a rapid, irregular pulse. After making a 'bedside' diagnosis of atrial fibrillation, the physician administers digitalis. The patient . . . is soon moribund (P.A.T. with Block, naturally)." These very first words in the author's preface set the lively, staccato pace, sprightly tone, and straightforward unsophisticated approach with which this small (120 pages), but adequate book is written.

This text covers a limited area — arrhythmias, and in doing so creates a worthwhile service in helping to fill a neglected void. The author's humility in indicating that he has directed his efforts to general practitioners, anesthesiologists, and surgeons, but not to the "cardiologist" in his ivory tower, points up how he has managed to write a lithe, quick book unencumbered by multitudinous theories, sage controversies, and electronic age befuddlements. Whereupon, one can predict that "cardiologists" will be caught snipping tidbits to help teach others and enlighten murky areas in their own minds.

The first two chapters deal with the anatomy and physiology of the conducting tissues of the heart and basic facts and measurements of the electrocardiogram with an exceptionally lucid exposition of the electrical registration of the components of the heartbeat. The figures used to illustrate these chapters, as well as those following, are large, clear, definitive, and pertinent. The chapters which follow on the common, basic arrhythmias are adequately illustrated with numerous, well-chosen, electrocardiograph segments appropriately supplemented with diagrams. The composite use of illustrations and graph segments often tells a compact pictorial story where there would otherwise be a morass of words.

At the end of the book there are selected exercise electrocardiograms with answers hidden further on. This will prove fun for both the young (students) and old (cardiologists) — and what more can be asked of any book?

HARRY HECKER, M.D.

THE SCIENCE OF DREAMS by Edwin Diamond. Doubleday & Co., Inc., Garden City, N.Y., 1962. $4.50

This book deals with the study of past, present, and possible future developments in the science of dreams. The author has used a staggering amount of sources of information from primitive cultures,

concluded on page 346



A new answer to one of America's leading health problems

60 DELICIOUS FOODS THAT MAKE WEIGHT CONTROL EASIER!

Here is a practical and down-to-earth method to help overcome obesity, the nation's No. 1 diet problem—and prime stealer of doctor's consultation time. Now a new group of 60 delicious Mott's Figure Control Food products uses the best of nutrition knowledge to create quality dishes, lower in calories by an average of 50%. Indicated calorie savings can be made pleasantly and accurately while eating normal-size portions by using these calorie-controlled foods in place of higher calorie dishes. Protein, vitamin and mineral food values are retained.

Low carbohydrate, low fat: Fats are largely extracted from meats and poultry in a way that cannot be done at home. Sauces and dressings are prepared with a high proportion of non-fat milk solids, vegetable colloids, all are delectably "natural" and tempting in flavor. Fruits, juices, desserts and sauces are prepared where indicated with non-caloric sweeteners—natural fruit values are intact, extra sugars reduced. The carbohydrate, protein and fat content appears on all labels along with the calorie count. Useful for diabetic diets, too.

Easy medical tool for doctors: Less need for drugs, no possible dangerous side effects, not even temporary dislocation of meal patterns. Figure Control Foods include: Soups, Meats & Poultry, Popular Sauces, Salad Dressings, Preserves, Syrup, Fruits, Drinks, Desserts and Sweeteners.

New Mott's Figure Control® Foods offer Good Eating at Half the Usual Calories

	Quantity	Figure Control Calories	"Regular" Food Calories
Apple-Grape Drink	½ cup	20	52
Five-Fruit Juice Breakfast Drink	½ cup	20	52
Braised Beef and Vegetables	6½ oz.	184	380
Meat Balls in Brown Gravy	3½ oz.	84	280
Chopped Chicken Livers	1 oz.	31	100
Chicken a la King	3 oz.	72	230
French Style Dressing	1 tbsp.	10½	60
Brown Gravy	1 tbsp.	7	21

	Quantity	Figure Control Calories	"Regular" Food Calories
Applesauce	½ cup	48	90
Fruit Cocktail	½ cup	44	90
Cherry Pie Filling	1 oz.	20	60
Chocolate Topping	1 tbsp.	8	63
Preserves (Peach, Strawberry)	1 tbsp.	9	55
"Maplette" Syrup	1 tbsp.	9	55
Liquid or Powder Sweetener	(to equal 1 tbsp. of sugar)	0	16



Complete menus, recipes, calorie chart available for professional distribution, with weight control guides you can distribute with confidence: all menus meet N.R.C. Recommended Daily Allowances. **Use this handy order form:**

FIGURE CONTROL FOODS
Duffy-Mott Company
370 Lexington Avenue
New York 17, New York

Please send____free copies of YOUR WEIGHT CONTROL PLAN for use with patients.

Dr._____

Address:_____

City:_____ Zone:____ State:_____

BOOK REVIEWS

concluded from page 344

Old and New Testaments, up to the most recent experimentation in the fields of psychology, psychiatry, and physiology. For this reason, there is, of necessity, overcondensation. In spite of this (the author being a writer, journalist, and former university professor), the book is very readable with a new challenge in every chapter and will appeal to a large all-inclusive group of readers with varied intellectual background.

Mr. Diamond, who is well acquainted with psychoanalysis, describes the wealth of experimental laboratory data by which modern scientists (mostly American) have been able to validate or invalidate Freud's theories concerning the dream. I found the parallel between Freud's concepts and the cult of dreams of the Iroquois Indians (his predecessors of 300 years) quite fascinating. An unexpected finding was the discovery by Dr. Dement and others that dream (not sleep) deprivation leads to psychotic phenomena.

In the introduction the author expresses his acknowledgment to a large number of men in medicine, psychiatry, psychology, and other disciplines. The list is impressive qualitatively and quantitatively. I found this book informative and enjoyable.

CATHERINE ZOURABOFF, M.D.

SING WHILE YOU DRIVE — At 45 mph, sing: "Highways Are Happy Ways." At 55 mph, sing: "I'm But a Stranger Here, Heaven Is My Home." At 65 mph, sing: "Nearer My God to Thee." At 75 mph, sing: "When the Roll Is Called Up Yonder, I'll Be There." At 85 mph, sing: "Lord, I'm Coming Home."

(Reprinted from *Executives' Digest*)

THE PRESIDENT CONSULTS "THE DOCTORS"

From the White House, last week, came news dispatches of a very special conference. The President, loathe to endorse anything without first ascertaining its actual urgency and necessity, had invited a group of representative doctors to have tea with him and to advise him concerning his medical care for the aged plan. It appears that the American Medical Association and some other recalcitrant medical groups had been raising hob with the Administration's propaganda plans for the immedite passage of HR 4222, and Secretary Abraham A. Ribicoff had delayed his whirlwind around-the-country whooper-up campaign so that "Non-political doctors" would have the opportunity to put the organized non-conformists to shame.

But things did not go well. Forty-two carefully selected doctors were invited. "For one reason or another," the newspapers said the next day, "only twenty-five of the invited physicians could attend." The doctors who *could* attend unanimously and enthusiastically endorsed the Administration's plan.

Human Events takes it on from there:

"The Republican Congressional Committee's *Newsletter* last week ripped apart the Administration's gimmick designed to convince the public that the medical profession supports the President's medical care for the aged plan. The ploy by the White House, headlined by the liberal press, was a visit to the President by twenty five physicians who said they were for his health bill—now before the House Ways and Means Committee. The White House emphasized that three quarters of the physicians belonged to the American Medical Association.

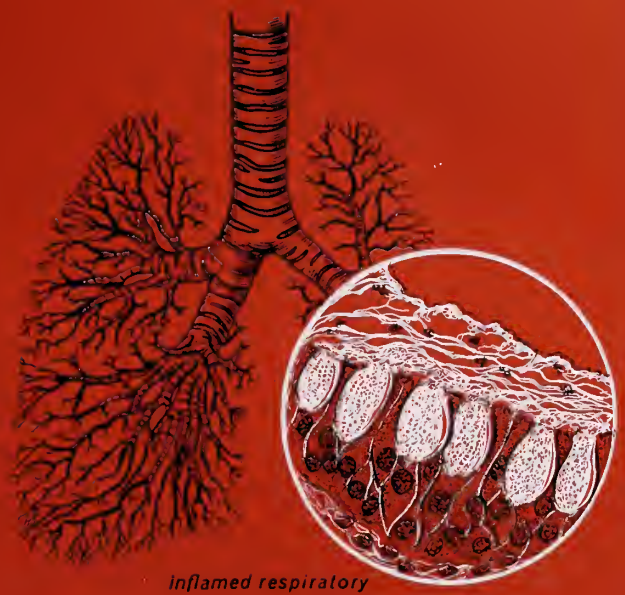
"The image created," said the *Newsletter*, "was one of twenty-five kindly, altruistic, old general practitioners whose only interest was in their fellow man, trooping to the Executive Mansion for the cause of Justice.

"The *Newsletter*, however, discovered that among these 'distinguished members of the medical profession'— as President Kennedy referred to them — were many former Democratic propagandists. One was chairman of the platform committee on health legislation at the past Democratic National Convention; seven of them had testified on behalf of other pressure groups; one had organized a 'Committee of Physicians' for Kennedy during the 1960 Presidential campaign; three are employed by international unions which support the plan; two are employees of Mayor Wagner, and one is the director of a hospital supported entirely by federal funds.

"And the clincher: "Of all those contacted," said the *Newsletter*, "none could be found who are in private medical practice."

... Reprinted from PHILADELPHIA MEDICINE, April 27, 1962

INDICATION: *Acute respiratory inflammation*



inflamed respiratory tract mucosa

INDICATED: Chymoral®

cuts healing time in RESPIRATORY INFLAMMATION

By subduing the inflammatory reaction of respiratory tract tissues, Chymoral liquefies thickened bronchial secretions and affords easier expectoration of mucus plugs. In a series of 48 patients with bronchial asthma, 44 were afforded relief with Chymoral therapy that was judged "good to excellent."[1] In chronic obstructive emphysema, Chymoral has improved both vital capacity and the ability to expectorate without severe, racking cough effort.[2] And in sinusitis or rhinitis there is a definite reduction of inflammation and edema of the nasal and sinal mucosa, along with improved airflow.[2,3]

controls inflammation
curtails swelling, curbs pain

1. Taub, S. J.: Clin. Med. 7:2575, 1960. 2. Clinical Reports to the Medical Department, Armour Pharmaceutical Company, 1960. 3. Billow, B. W.; Cabodeville, A. M.; Stern, A.; Palm, A.; Robinson, M., and Paley, S.S.: Clinical Experiences with Oral Anti-inflammatory Enzyme for Intestinal Absorption. Southwestern Med. *41*:286, 1960.

CHYMORAL

Chymoral is an ORAL anti-inflammatory enzyme tablet (enteric coated). Each tablet provides enzymatic activity, equivalent to 50,000 Armour Units, supplied by a purified concentrate which has specific trypsin and chymotrypsin activity in a ratio of approximately six to one. ACTION: Reduces inflammation of all types; reduces and prevents edema except that of cardiac or renal origin; hastens absorption of blood and lymph extravasates; helps to liquefy thick tenacious mucous secretions; improves regional circulation; promotes healing; reduces pain. INDICATIONS: In respiratory conditions, inflammatory dermatoses, gynecologic conditions, obstetrics, surgical procedures, genitourinary disorders, dental and oral surgery, in conjunction with generally accepted measures of therapy. Antibiotics may be administered simultaneously. INCOMPATIBILITIES: None known. CONTRAINDICATIONS: None known. SIDE EFFECTS: Mild gastric upsets, rarely encountered. DOSAGE: Recommended initial dose is two tablets q.i.d.; one q.i.d. for maintenance. SUPPLIED: Bottles of 48 and 250 tablets. • For elaboration of this information consult the package insert.

Issue: Rev. Nov. 1961

ARMOUR PHARMACEUTICAL COMPANY KANKAKEE, ILLINOIS *Originators of Listica®*

CHYMORAL *ORAL systemic anti-inflammatory enzyme tablet*

the first comprehensive regulator of female cyclic function

ENOVID®

(brand of norethynodrel with ethynylestradiol 3-methyl ether)



...unfettered

THE BASIC ACTION

ENOVID closely mimics the balanced progestational-estrogenic action of the functioning corpus luteum. This action is readily understood by a simple comparison. In effect, ENOVID *induces a physiologic state which simulates early pregnancy—except that there is no placenta or fetus.* Thus, as in pregnancy, the production or release of pituitary gonadotropin is inhibited and ovulation suspended; a pseudodecidual endometrium ("pseudo" because neither placenta nor fetus is present) is induced and maintained.

Further, during ENOVID therapy, certain symptoms typical of normal pregnancy may be noted in some patients, such as nausea—which is usually mild and disappears spontaneously within a few days—breast engorgement, some degree of fluid retention, and often a marked sense of well-being. There is no androgenicity. ENOVID *is as safe as the normal state of pregnancy.*

THE BASIC APPLICATIONS

1. Correction of menstrual dysfunction. *Emergency* treatment of severe dysfunctional uterine bleeding is promptly effective following the administration of ENOVID in larger doses. *Cyclic* therapy with ENOVID controls less severe dysfunctional uterine bleeding. In amenorrhea *cyclic* therapy with ENOVID establishes a pseudodecidual endometrium providing the patient has endometrial tissue capable of response.

2. Ovulation suppression (to suspend fertility). For this purpose ENOVID is administered *cyclically,* beginning on day 5 through day 24 (20 daily doses). The ovary remains in a state of physiologic rest and there is no impairment of subsequent fertility. When ENOVID is prescribed for this *cyclic* use over prolonged periods, a total of twenty-four months should not be exceeded until continuing studies indicate that its present lack of undesired actions continues for even longer intervals. Such studies are now in their seventh year and will regularly be reviewed for extension of the present recommendation.

3. Adjustment of the menses for reasons of health (impending hospitalization for surgery, during treatment of Bartholin's gland cysts, acute urethritis, rectal abscess, trichomonal or monilial vaginitis), or other special circumstances considered valid in the opinion of the physician. For this purpose ENOVID may be started at any time in the cycle up to one week before expected menstruation. Upon discontinuation, normal cyclic bleeding occurs in three to five days.

4. Endometriosis. *Continuous* therapy with ENOVID corrects endometriosis by producing a pseudodecidual reaction with subsequent absorption of aberrant endometrial tissue.

5. Threatened and habitual abortion. ENOVID should be used as *emergency* treatment in *threatened abortion* although symptoms may occur too late to be reversible. *Continuous* therapy with ENOVID in *habitual abortion* is based on the physiology of pregnancy. ENOVID provides balanced hormone support of the endometrium, permitting continuation of pregnancy when endogenous support is otherwise inadequate.

6. Endocrine infertility. ENOVID has been used successfully in *cyclic* therapy of endocrine infertility, promoting subsequent pregnancy through a probable "rebound" phenomenon.

THE BASIC DOSAGE

Basic dosage of ENOVID is 5 mg. daily in *cyclic* therapy, beginning on day 5 through day 24 (20 daily doses). Higher doses may be used with complete safety to prevent or control occasional "spotting" or breakthrough bleeding during ENOVID therapy, or for rapid effect in the *emergency* treatment of dysfunctional uterine bleeding and threatened abortion.

ENOVID is available in tablets of 5 mg. and 10 mg. Literature and references, covering more than six years of intensive clinical study, available on request.

SEARLE *Research in the Service of Medicine*

The RHODE ISLAND MEDICAL JOURNAL

VOL. XLV JULY, 1962 NO. 7

The Caleb Fiske Prize Essay, 1961

CURRENT STATUS OF CARDIAC SURGERY*

LESTER L. VARGAS, M.D.

The Author. *Lester L. Vargas, M.D., of Providence, Rhode Island. Surgeon-in-Chief, Department of Surgery, and Director of the Cardiovascular Surgical Research Laboratory, Rhode Island Hospital, Providence, Rhode Island. Assistant Clinical Professor of Surgery, Tufts University School of Medicine, Boston, Massachusetts.*

AN EXCITING surgical frontier was opened in 1938 by Gross[1] when he demonstrated the clinical feasibility of obliterating a patent ductus arteriosus. In 1945 Blalock and Taussig[2] successfully employed a shunt between a branch of the aorta and a pulmonary artery to relieve the symptoms of a tetralogy of Fallot anomaly. In the same year, Crafoord and Nylin[3] resected a coarctation of the aorta, and Gross[4] divided an obstructing vascular ring.

Intracardiac surgery for the relief of acquired mitral stenosis was introduced independently by Harken[5] and Bailey[6] in 1948. These notable contributions, which showed that certain intracardiac lesions were amenable to blind techniques, provided the research stimulus which led a number of ingenious surgeons to attempt a variety of closed methods to repair other intracardiac defects. While some of these efforts were rewarded with success, others were followed by failure and frustration and emphasized the need for a technique which would permit direct vision intracardiac surgery.

The first suggestion that open-heart surgery was indeed possible came from Canada in 1950 where Bigelow and his associates[7,8] showed that circulatory arrest for periods up to eight minutes was possible in dogs cooled to a body temperature of 30 degrees Centigrade. Subsequently, hypothermia together with venous inflow occlusion was employed clinically by Lewis,[9] Swan,[10] and others. However, it was soon apparent that only a limited number of simple intracardiac lesions could be precisely repaired within the time limit of eight minutes imposed by the technique. Even the most rapid and dexterous surgeons recognized that the future of cardiac surgery depended upon finding a method that would provide sufficient time in an open, quiet, and dry field to deal with every complex intracardiac lesion.

Lillehei[11] achieved these objectives in 1954 when he employed a living human donor to whom the venous and arterial systems of the patient were connected via plastic tubing and appropriate pumps. Complete heart-lung bypass in the patient was then possible by controlled cross-circulation. Using this method, he was the first to close defects in the ventricular septum and to completely repair the multiple defects associated with tetralogy of Fallot. In the same year Gibbon[12] reported closing an atrial septal defect in an 18-year-old girl utilizing a heart-lung machine. This accomplishment culminated twenty years of careful research by this dedicated investigator and stands as a brilliant achievement in the progress of surgery. The enthusiasm which followed Gibbon's contribution and the vigor with which the techniques of extracorporeal circulation were pursued in the laboratory and clinic led to the development of several different pump-oxygenators and to a growing list of successfully treated patients.

The techniques of extracorporeal circulation which have made possible the surgical conquest of both congenital and acquired intracardiac lesions form the basis of this discussion. This is a selective, descriptive, and interpretive essay and is derived for the most part from the author's personal laboratory and clinical experience.

PART I. EXTRACORPOREAL CIRCULATION

The concept that a mechanical device could be used to substitute for the function of the heart and lungs is not new. Gollan[13] quotes Le Gallois who wrote in 1882: "If one could substitute for the heart a kind of injection of arterial blood, either natural

continued on next page

*From the Department of Surgery, Rhode Island Hospital, Providence, Rhode Island. Presented at the Sesquicentennial Meeting of the Rhode Island Medical Society held at Brown University, Providence, Rhode Island, May 9, 1962.

Supported by grants from the John A. Hartford Foundation, Inc., the Rhode Island Heart Association, and the Rhode Island State Heart Disease Control Program.

or artificially made, one would succeed easily in maintaining alive indefinitely any part of the body whatsoever." While indefinite maintenance of life with the aid of an extracorporeal circulation is yet to be achieved, total heart-lung bypass by this method for limited periods of time is a clinical reality.

Description of the Apparatus

Although several complete pump-oxygenators are now commercially available, the number of varied combinations of different pumps, oxygenators, and reservoirs which are currently being used successfully appear to be limited only by the imagination and ingenuity of those who employ them. The heart-lung machine ultimately selected for use by the author was chosen from a number of different components, each of which was repeatedly modified and improved in the laboratory (Figs. 1 and 2). It consists of five essential parts: 1) a venous collecting reservoir, 2) a multiple suction system, 3) an oxygenator, 4) an arterial pump, and 5) a heat exchanger.

A collecting reservoir is located approximately 40 to 60 centimeters below the level of the operating table. The entire venous return to the patient's heart is drained by siphonage through cannulae introduced into the superior and inferior venae cavae and connected to separate tygon plastic tubes entering the bottom of the reservoir. Whenever decompression of the left heart chambers is considered necessary, an additional cannula drains either the left atrium or ventricle into this reservoir.

During cardiotomy, blood returning from the coronary sinus, the Thebesian vessels, and sometimes from a well-developed bronchial collateral circulation, must be aspirated and returned to the extracorporeal circuit. Early experience indicated that several aspirating systems used simultaneously were required to ensure complete recovery of blood losses at the operative field. Blood from the coronary sinus is aspirated by a gentle, continuous vacuum and returned to a negative pressure reservoir where effective debubbling occurs. A constant level is maintained in this reservoir by a mercury toggle-switch coupled to a plastic float. Any elevation of the float by incoming blood automatically triggers a pump which delivers blood to the collecting reservoir (Fig. 3). Two additional aspirators are employed. The source of vacuum is a DeBakey-type roller pump which delivers the foamed blood to a second debubbling reservoir. A vacuum can be quickly applied to this reservoir, eliminating the need for the roller pump in the event of a power failure. Foamed blood reverts to a fluid state when it contacts shredded tygon strips which have been lightly sprayed with a silicone oil. It then flows into the collecting reservoir. Since any residual bubbles in blood tend to rise to the surface, this system of blood collection provides that each reservoir serves also as a bubble trap.

Blood from the collecting reservoir flows by gravity into an oxygenator or artificial lung. The

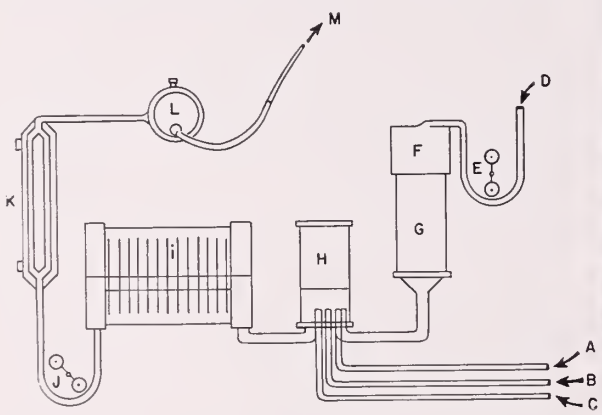


FIGURE 1

Schematic drawing of pump-oxygenator. A and B–caval drainage tubes, C–left heart decompression tube, D–cardiotomy suction tube, E–pump, F–debubbling chamber, G–debubbling reservoir, H–collecting reservoir, I–disc-oxygenator, J–roller pump, K–heat exchanger, L–filter and bubble trap, M–arterial cannula.

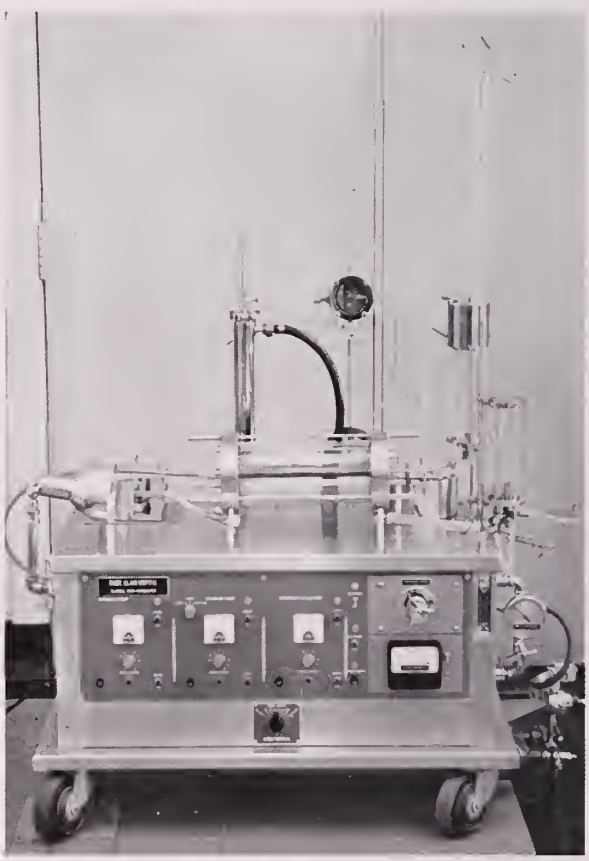


FIGURE 2

Pump-oxygenator fitted with Brown-Emmons Heat Exchanger which is currently used clinically.

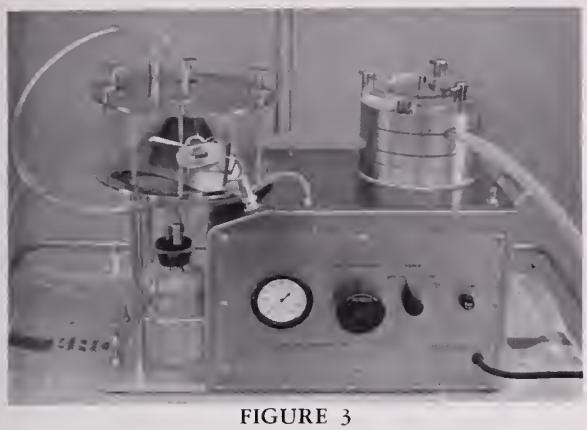


FIGURE 3
Coronary sinus aspirator and debubbling reservoir.

basic principle employed is the exposure of a thin film of blood to an oxygen atmosphere on a series of silicone-coated stainless steel discs. This method of oxygenating blood was introduced by Björk[14] and subsequently modified by Cross and his associates.[15] The discs are mounted at intervals on a central rotating shaft. The disc assembly is supported within a pyrex glass cylinder by gasketed stainless steel end-plates. The length of the cylinder and the number of discs employed are determined by the size of the patient and the flow requirements. It has been found that a patient under anesthesia and at normal body temperature requires an average of 100 milliliters of oxygen per square meter of body surface area per minute. It is also possible to determine, for any given oxygenator, the oxygen transfer of a single disc per minute. In the apparatus described here, this has been calculated to be 1.25 milliliters per minute. Thus, the size of the oxygenator and the number of discs required can be very accurately tailored to meet the needs of any patient. The shaft and discs are rotated at a speed of 110 r.p.m. by an electric motor through a flexible cable. Blood from the venous-collecting reservoir is introduced at the bottom of the venous end-plate and is withdrawn from a comparable point at the opposite end of the oxygenator cylinder. The oxygenator is primed with sufficient blood to immerse the discs 4 centimeters. A mixture of oxygen and carbon dioxide is delivered through the entire length of the oxygenator through two stainless steel tubes. The tubes are perforated at appropriate intervals so as to supply the gas mixture to each pair of discs.

Oxygenated blood withdrawn from the bottom of the arterial end-plate is returned to the patient by means of a modified DeBakey-Gibbon pump.* The pump propels blood by compressing a plastic tube with a centrally pivoted pair of rollers. The arm of each roller can be adjusted precisely, and the degree of compression of the tube can be varied from zero to full occlusion. Valves are not necessary since each roller takes up the compression where the other leaves off.

*Custom-machined according to our specifications by Mr. Raymond C. Hill and Mr. George Clentimack, North Attleboro, Massachusetts.

Precise control of the temperature of blood returning to the patient is achieved with a heat exchanger designed by Brown and his associates.[16] In this device, blood flows through a water jacket within a series of thin, stainless-steel tubes. By altering the temperature of the water circulating through the heat exchanger, blood temperature can be either raised or lowered. A heat exchanger of greater capacity, designed by Hufnagel and his associates,[17] is also available for the rapid cooling of adult patients (Fig. 4). Blood then passes through a filter and bubble trap and is returned to the patient.

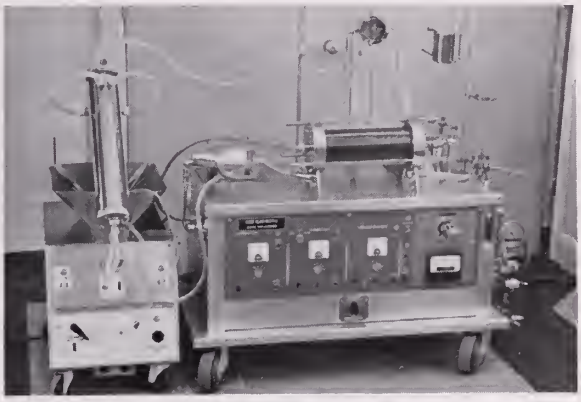


FIGURE 4
Pump-oxygenator fitted with a Hufnagel-Brunswick Heat Exchanger.

Conduct of Complete Heart-Lung Bypass

Under Fluothane anesthesia the patient's heart and femoral vessels are exposed simultaneously by two operating teams. A median sternal-splitting incision is used except when the left atrium is to be entered from a right thoracic approach. Under these circumstances, a conventional right thoracotomy through the fifth interspace is employed. The pericardium is opened widely, and both venae cavae are encircled with umbilical tape close to where they enter the right atrium. Whenever possible, the inferior vena cava is cannulated with as large a plastic catheter as can be introduced through the common femoral vein. This reduces the number of tubes present in the operative field and greatly simplifies the procedure. The superior vena cava is cannulated with a similar catheter introduced through a stab wound in the right atrial appendage and is secured with a purse-string suture. A stainless-steel cannula* is inserted into the common femoral artery. When necessary, the left heart is decom-

*Cannulae together with tapered adapting plastic tubing generously supplied by the Davol Rubber Company, Providence, Rhode Island.

continued on next page

pressed by a catheter introduced into the left atrium or ventricle (Fig. 5). At the start of the cannulations, Heparin is administered intravenously in a dosage of one milligram per pound of body weight. All cannulae are connected to the heart-lung machine via tygon plastic tubing with an inside diameter of three-eighths of an inch.

Partial heart-lung bypass is begun by starting the arterial pump and simultaneously permitting the caval catheters to drain by siphonage into the collecting reservoir. After a few minutes complete bypass is achieved by tightening the caval tourniquets. The arterial pump speed is adjusted so as to maintain a constant level of blood in the oxygenator at the predetermined flow rate. Under normothermic conditions, perfusion rates of 2.2 to 2.4 liters per minute per square meter of body surface area are employed.

The mean arterial and central venous pressures of all patients are recorded continuously through fine catheters introduced into the left radial artery and into the vena cava via a saphenous vein. A single-lead (brow to occiput) electroencephalogram is also monitored throughout the perfusion.

Blood used for priming the apparatus and to replace operative losses is collected on the morning of operation from fasting donors. The blood is drawn by gravity into plastic bags containing 20 milligrams of Heparin for each 500 centimeters of blood.

At the completion of cardiopulmonary bypass, the Heparin effect is neutralized by Polybrene.*

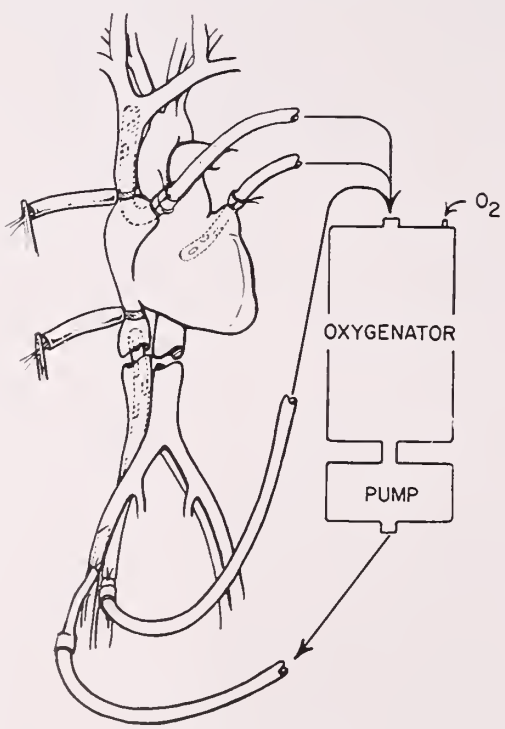


FIGURE 5
Drawing showing scheme of cannulation.

The amount of Polybrene given is calculated to equal twice the Heparin dose. Half of the required Polybrene is administered rapidly over a period of five to ten minutes. The remaining dose is then infused slowly with the aid of a microdrip over a period of thirty minutes. The venous clotting time is determined at intervals of ten minutes and the Polybrene drip discontinued when the clotting time has returned to normal.

Although our initial experience in utilizing extracorporeal circulation under normothermic conditions was gratifying, we were aware that occasional technical difficulties and the increasing duration and complexity of certain intracardiac procedures required a wider margin for safety. This led to our exploring the use of combined hypothermia and extracorporeal circulation.

Perfusion Hypothermia

The effect of total body cooling in depressing metabolic processes had been demonstrated by Temple Fay[18] in 1940. Subsequent studies by Bigelow and his associates,[7,8] Swan and his colleagues,[10] and by Lewis[9] confirmed the fact that oxygen consumption of body tissues fell steadily with decreasing body temperature. These investigators successfully utilized hypothermia at levels between 25 and 30 degrees Centigrade, achieved by external cooling, to allow total circulatory arrest for short periods of time and the performance of certain simple operations within the open heart. While it was known that deeper levels of hypothermia would extend the period of safe circulatory interruption, lower temperatures could not be employed safely by this technique because of the danger of cardiac arrhythmias and ventricular fibrillation. The fact that the human being could tolerate profound levels of hypothermia if ventricular fibrillation did not occur had been reported by Laufman[19] who described a patient whose body temperature fell to 18 degrees Centigrade following accidental exposure to cold. Niazi and Lewis[20] successfully cooled a 51-year-old woman with a terminal cancer of the ovary to nine degrees Centigrade. Cardiac and respiratory stand-still persisted for one hour at this low temperature, and normal cardiorespiratory activity was restored after rewarming. On the basis of this evidence, it was apparent that profound hypothermia could be employed clinically to permit lengthy intracardiac operative procedures if two requirements were met: 1) an efficient technique for rapidly cooling and rewarming the patient, and 2) an extracorporeal pump to maintain the circulation when ventricular fibrillation occurred during the cooling and rewarming phases of the procedure.

*Generously supplied by Abbott Laboratories, North Chicago, Illinois.

In 1954 Gollan and his associates[21] showed that the combination of moderate hypothermia together with extracorporeal circulation and oxygenation permitted the use of relatively low blood flow rates (30-40 milliliters per kilo of body weight per minute) to satisfy the oxygen requirements of the body and prevent anoxic brain damage. This technique has since been widely employed clinically, particularly by Sealy and his associates.[22,23] The design of an efficient blood heat exchanger by Brown and his co-workers[16] has given further impetus toward utilizing extracorporeal cooling techniques.

A detailed review of the physiological data derived from our laboratory and clinical studies is beyond the scope of this paper. The most important data is summarized in Figures 6, 7, and 8.

In practice we employ some degree of perfusion hypothermia for all but the simplest intracardiac procedures. A Brown-Emmons Heat Exchanger is adequate for use in children and in cases where moderate levels (30 degrees Centigrade) of hypothermia are employed in adults. For profound hypothermia (15 to 20 degrees Centigrade), a Hufnagel-Brunswick Heat Exchanger is required. As the body temperature falls, the oxygen requirements of the tissues diminish. This is readily apparent by an increased redness of the venous blood returning to the pump, indicating a decreasing arterio-venous difference of oxygen saturation. As the venous return diminishes, the arterial output of the pump similarly can be reduced. Thus, the greater simplicity gained in operating the apparatus at low flow rates significantly increases the margin of safety of the method. Total circulatory arrest at profound levels of hypothermia where the pump-oxygenator is turned off for brief periods is also possible. This is sometimes necessary for the complete correction of complex tetralogy of Fallot anomalies.

The lessons learned by the application of extracorporeal circulation and cooling have led some investigators[24-27] to study the application of profound hypothermia induced by an extracorporeal pump and autogenous oxygenation utilizing the patient's own lungs. This method requires that all circulation be interrupted during the period of actual intracardiac surgery. For the more complicated intracardiac surgical procedures, body temperatures below 15 degrees Centigrade must be reached to permit circulatory arrest for periods of thirty minutes. The advantages of profound hypothermia without the use of an artificial oxygenator have been enumerated by Björk[28] and by Holt and his associates.[29] The attendant problems of siliconizing and priming are eliminated when an oxygenator is not used. A priming volume of 1,000 milliliters of fresh heparinized blood will suffice,

continued on next page

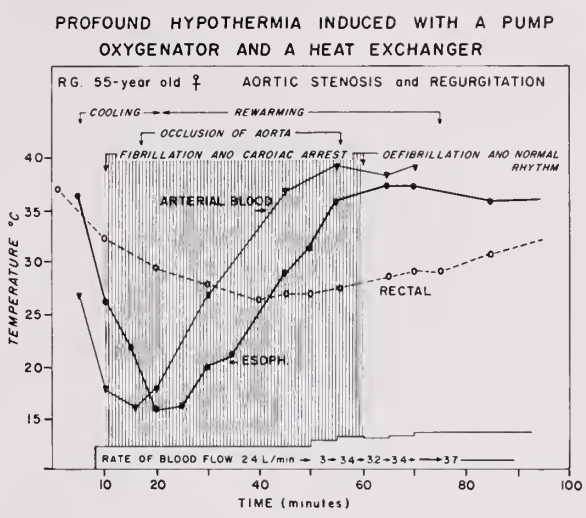


FIGURE 6

Profound hypothermia induced with a pump-oxygenator and heat exchanger.

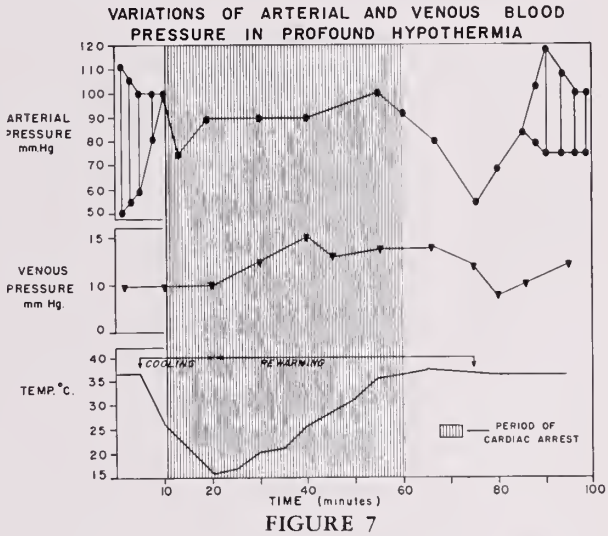


FIGURE 7

Variations of arterial and venous blood pressure in profound hypothermia.

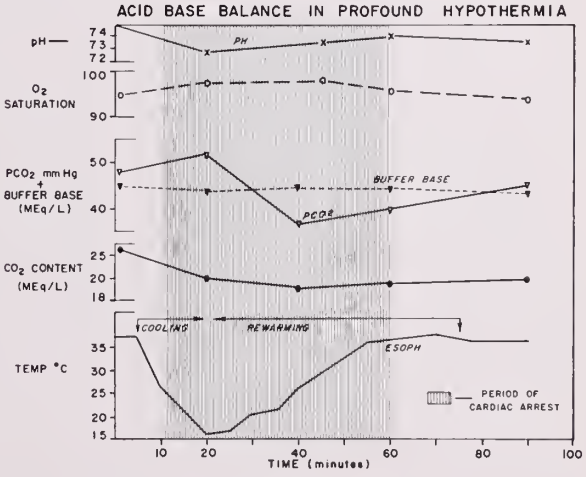


FIGURE 8

Acid-base balance in profound hypothermia.

regardless of the size of the patient or the required blood-flow rate. Moreover, oxygenation of the blood by the patient's own lungs is admittedly superior to any artificial oxygenating device. The alluring prospect of eliminating the oxygenator from the perfusion apparatus stimulated our studying the method in experimental animals. The technique of bypassing the right and left sides of the heart is shown in Figure 9. The circulation in anesthetized mongrel dogs was arrested for varying periods up to one hour when temperature recorded from the esophagus reached 10 degrees Centigrade. During this time various kinds of intracardiac procedures were performed.

The results of these experiments convinced us that complete circulatory arrest under profound hypothermia provided ideal operating conditions. Cardiac arrest occurred at temperatures below 20 degrees Centigrade, and with both pumps turned off a quiet, dry, operative field was achieved. However, it was also apparent that all parts of the body did not cool at the same rate. While the internal organs reached low temperatures during rapid cooling, the temperature of the muscle mass lagged. Anaerobic metabolism in the warmer parts of the body during circulatory arrest resulted in the accumulation of fixed acids (lactate and pyruvate) and metabolic acidosis. The severity of these changes was directly proportional to the duration of circulatory arrest and was usually irreversible after a period of thirty minutes. In the author's experience the more complicated intracardiac lesions require at least sixty minutes for their precise correction. In addition, Björk[28] and Kirklin[30] have reported brain damage in patients whose circulations have been interrupted for periods longer than one-half hour. For these reasons, we have not employed this method clinically and prefer to utilize an oxygenator and only brief (ten to fifteen minutes) periods of circulatory arrest.

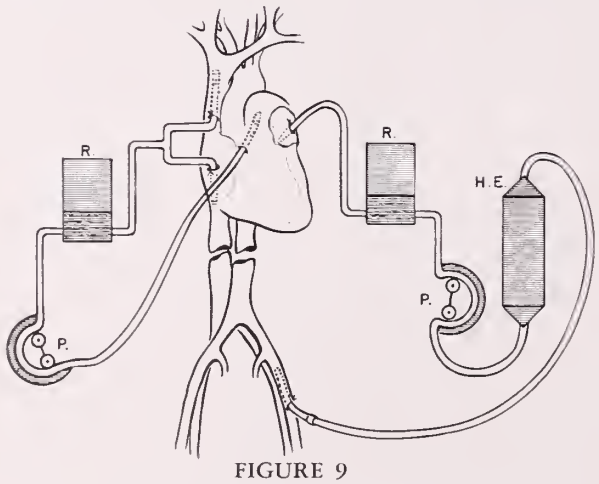


FIGURE 9

Scheme of extracorporeal circuits in profound hypothermia and autogenous oxygenation. P–right and left heart pumps, R–reservoirs, HE–heat exchanger.

Elective Cardiac Arrest

An operative field which is motionless and virtually dry is essential for the expeditious repair of certain complicated intracardiac defects. While extracorporeal circulation techniques have made open-heart surgery possible, blood returning from the coronary sinus or via an augmented bronchial collateral circulation and sometimes from the aorta through a valve temporarily rendered insufficient by operative manipulation may mitigate against a precise repair or prolong the necessary period of cardiopulmonary bypass. Optimum operating conditions require that: 1) the heart must be stopped, and 2) the flow of blood through the coronary arteries must be temporarily interrupted.

Lillehei[31] effectively employed intermittent occlusion of the ascending aorta to limit the inflow of blood from the coronary sinus and reflux through the aortic valve. Prolonged occlusion of coronary blood flow led to anoxic cardiac arrest, and this technique has been successfully employed for limited periods of time by Cooley[32] and others.[33] In 1955 Melrose and his associates,[34] employing the pharmacological principles established by Ringer,[35] demonstrated that potassium citrate could be employed clinically to promptly effect "elective cardiac arrest." In the same year Lam and his co-workers,[36] following the lead of Senning,[37] successfully utilized acetylcholine as a clinically effective cardioplegic agent. However, regardless of the method by which elective cardiac arrest was induced, it became increasingly evident that at normal body temperatures the metabolic requirements of the non-beating, nonworking heart were not significantly changed and that the safe period of arrest could not exceed thirty minutes. Moreover, there is now abundant evidence to show that these cardioplegic agents themselves are toxic to the myocardium.[38–40] Glenn and his associates,[41] recognizing the dangers of prolonged myocardial anoxia, employed a technique whereby ventricular fibrillation was deliberately induced by an electric current. However, blood returning from the coronary circulation and the bronchial collaterals continued to flood the operative field and limited the usefulness of their method.

In an effort to extend the safe period of asystole, Urschel and his associates[42] employed a method of differentially cooling the heart while maintaining the body at moderate hypothermic levels with the aid of an extracorporeal circulation. The induction of selective, deep, cardiac hypothermia produced an effective arrest without the use of drugs. At the same time, the method reduced the metabolic requirements of the heart and afforded protection against anoxia. Rapid arrest and reversibility were possible without protracted total body cooling.

Following the lead of these investigators, we have employed a technique for selective profound

cardiac hypothermia in the laboratory and clinically which is similar to one described by Hufnagel and his associates.[43] Cardiopulmonary bypass with a pump-oxygenator and rapid cooling is accomplished by the techniques described above. When the patient's body temperature reaches 30 degrees Centigrade, a slush of buffered Ringer-Locke solution is applied externally to the heart. The marsupialized pericardium contains the slush, and a sump suction device removes the melted solution which is replaced as necessary by freshly frozen slush. When only brief periods of cardiac arrest are anticipated, filling the pericardium with Ringer-Locke solution at 5 degrees Centigrade is adequate (Figure 10). Body cooling is continued until the esophageal temperature reaches 20 degrees Centigrade at which time the aorta is cross-clamped. Under these circumstances, the temperature of the heart as measured in the laboratory with a thermistor temperature probe is approximately 15 degrees Centigrade. Cardiac arrest uniformly occurs within one to three minutes following the application of the ice slush and persists until the aortic clamp is released. After the ascending aorta has been occluded, the body is rewarmed and maintained at 30 degrees Centigrade until the completion of the operation. Restoration of a sinus rhythm frequently results when the aortic occluding clamp is released and warm, oxygenated blood is allowed to perfuse the coronary circulation. When fibrillation occurs, a single, defibrillating electric shock usually restores a normal cardiac rhythm. This method has been employed clinically whenever cardioplegia has been necessary. It has been found that arrested cardiac activity can be rapidly produced, easily maintained, and consistently reversed to a normal sinus rhythm.

PART II

INTRACARDIAC LESIONS AMENABLE TO SURGICAL CORRECTION

1. CONGENITAL DEFECTS

Atrial Septal Defects

The variable location of atrial septal defects as well as their possible association with anomalous pulmonary venous drainage into the right heart or anomalies of the inferior vena cava has convinced us of the need for utilizing a pump-oxygenator to permit their complete correction. While simple foramen ovale defects can be repaired within the accepted time limits of hypothermia following surface cooling,[44] many cardiac surgeons feel that the more complicated lesions cannot.[45–48] If septum primum defects are excluded, the surgical mortality should be less than 5 per cent for the open repair of atrial septal defects. Moderate degrees of pulmonary hypertension may often disappear following closure of the defect.[49]

A pulmonary blood flow equal to twice the systemic blood flow determined by cardiac catheterization has been accepted in most clinics as an indication for surgical correction. However, increasing experience in our own clinic as well as in others now suggests that surgical treatment is indicated in virtually every patient on whom the diagnosis is made. While some patients may be asymptomatic, a considerable number of these will

continued on next page

SELECTIVE HYPOTHERMIC ARREST

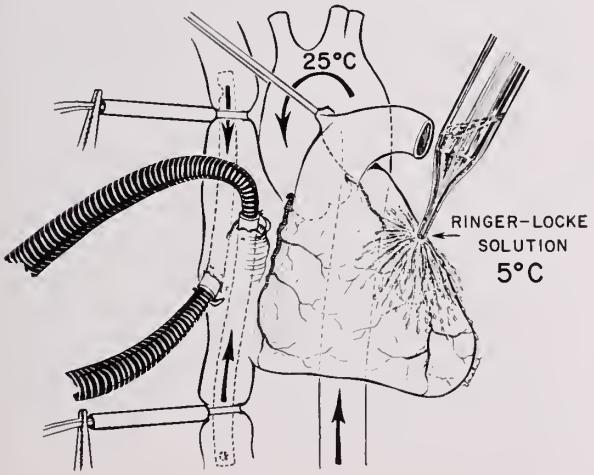


FIGURE 10a

Cold cardiac arrest. Profound systemic hypothermia and local cardiac cooling.

SELECTIVE HYPOTHERMIC ARREST

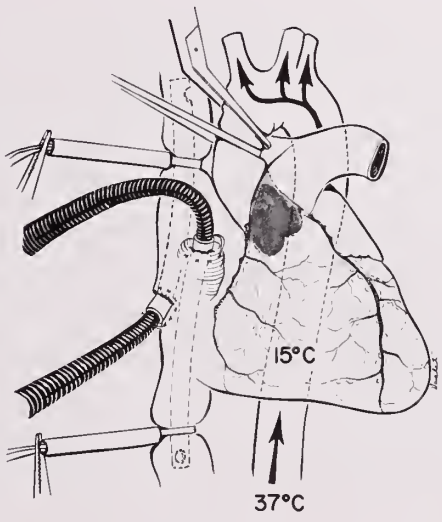


FIGURE 10b

Cold cardiac arrest. Systemic rewarming after cross-clamping of aorta and persistent cold heart.

eventually deteriorate. Since there is no method by which the course of these patients may be predicted, it would appear reasonable to consider this lesion in the same way as one does a patent ductus arteriosus.

Anomalous Pulmonary Venous Drainage

Abnormalities of pulmonary venous drainage into the right atrium are usually associated with atrial septal defects. Frequently, the defect is in the posterior septum and overrides the right pulmonary vein orifices. In other instances the right pulmonary veins drain into the superior vena cava. Most of these anomalies can be effectively treated by an open method where the septum is displaced and the atrial defect corrected so as to divert the pulmonary blood flow into the left atrium. Under certain circumstances it may be necessary to employ patches of teflon or dacron to effect such diversion. When most of the pulmonary veins drain into a common chamber which, in turn, drains into the coronary sinus or into either vena cava, intracardiac partitioning is essential. Only occasional success in treating these lesions by a closed method has been reported.[50] A precise and secure correction is time consuming and requires an open technique utilizing a pump-oxygenator.[51]

Endocardial Cushion Defects

Failure of the embryonic endocardial cushions to fuse results in a variety of intracardiac defects. These may range from a simple primum defect of the atrial septum with or without a cleft mitral leaflet to the complete form where the atrial defect is continuous with a defect in the membranous ventricular septum, and the adjacent mitral and tricuspid valve leaflets are divided by a continuous cleft.[52] These are among the most difficult intracardiac lesions to repair and clearly require an extracorporeal circulation.[53] A prosthetic patch is always necessary to effect closure of the defect together with meticulous repair of the valve leaflets. The repair employed successfully in a 5-year-old boy with such a defect is shown in Figure 11. Surgical treatment is indicated as soon as this lesion is diagnosed since pulmonary hypertension frequently results in death if repair is not attempted.

Pulmonary Valvular and Infundibular Stenosis

Pulmonary valvular stenosis was originally thought to be an uncommon congenital anomaly. However, increasing application of cardiac catheterization techniques has resulted in the diagnosis being made in approximately 10 per cent of patients with congenital heart disease. Characteristically, the commissures are fused and the valve projects into the pulmonary artery as a dome with a small central orifice. When valvular stenosis is severe, hypertrophy of the crista supraventricularis and other muscle trabeculae also create infundibular obstruction. Isolated infundibular stenosis occurs less frequently. It is usually situated about 1 to 3 centimeters below the normal valve as a localized thickened muscular diaphragm with a central orifice. Demonstration of pressure gradients greater than 60 millimeters of mercury across the obstruction by cardiac catheterization, in our opinion, is an indication for operative therapy. In most cases cineangiocardiography will distinguish between valvular and pure infundibular stenosis.

Blind valvulotomy by the Brock[54] technique does not always relieve the obstruction adequately and is best reserved for desperately ill infants who cannot tolerate an open operation. Direct vision valvu-

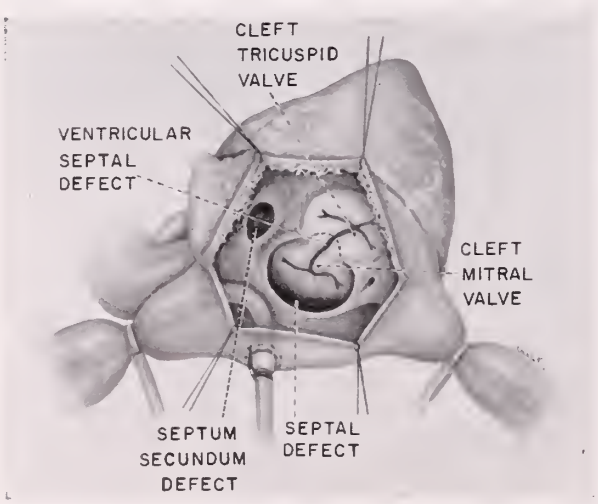


FIGURE 11a

Complete endocardial cushion defect, "Atrioventricularis Communis." Steps in the complete repair.

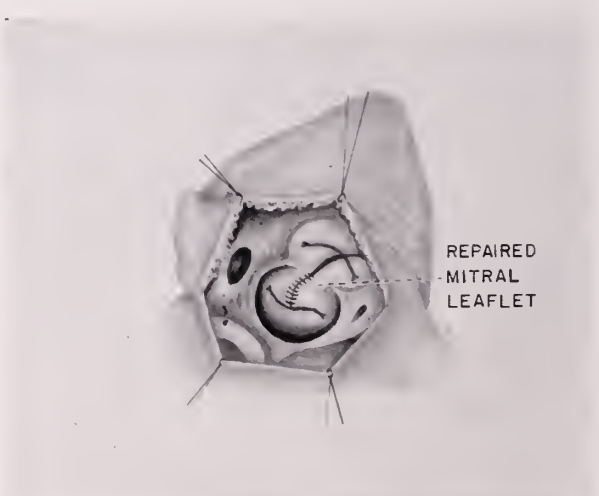


FIGURE 11b

Complete endocardial cushion defect, "Atrioventricularis Communis." Steps in the complete repair.

lotomy under simple hypothermia continues to be used by many surgeons whose excellent results cannot be questioned.[55] However, we as well as others[56-58] favor the use of extracorporeal circulation in order to accomplish a precise valvulotomy and to carry out a careful exploration of the ventricular outflow tract. By this method any associated intracardiac defects can be effectively treated whether or not they have been accurately diagnosed preoperatively. The risk of open operation for this lesion is now comparable to that for the repair of an atrial septal defect.

Ventricular Septal Defects

Defects can occur anywhere in the ventricular septum but are most commonly located in the membranous portion. Among children born with this defect, 60 per cent die in their first year of life and 20 per cent succumb between the ages of 4 and 15 years.[59] Most cardiologists and surgeons agree that operative correction is indicated in all symptomatic patients. The selection of non-symptomatic patients depends upon the demonstration of an elevated right ventricular and pulmonary artery pressure together with increased pulmonary vascular resistance.

When operation is undertaken before there is any significant elevation of these parameters, the risk in the hands of a well-trained team is small.[60,61] There is now abundant evidence to show that the operative risk is proportional to the degree of pulmonary hypertension.[62] While it is true that some patients will tolerate high-flow left-to-right shunts for long periods of time, there are others who unpredictably and suddenly develop high pulmonary artery pressures. It is in this group where procrastination about operating may mitigate against a successful outcome.

Open correction of these defects is time consuming and an extracorporeal circulation is essential. We prefer perfusion cooling to a body temperature of 25 degrees Centigrade. Accurate placement of sutures in the rim of the defect is necessary if the bundle of His and heart block is to be avoided. For this reason we avoid inducing cardiac arrest but, instead, intermittently occlude the aorta for brief periods.

Direct suture closure is possible in small defects with fibrous rims. A plastic sponge patch is employed for larger defects where it is necessary to avoid tension and cutting through of the sutures (Figure 12).

A serious complication following surgical closure of ventricular septal defects is the development of complete heart block. In many cases this arrhythmia is transitory and probably results from edema around the conducting bundle. Implanted myocardial electrodes and electrical cardiac pacemakers are of assistance in the management of this problem.[63] However, if complete heart block is permanent, the prospect for long-term survival is poor.

Aorticopulmonary Septal Defects

This rare congenital heart anomaly, sometimes referred to as a partial truncus, consists of an opening between the pulmonary artery and the aorta immediately above the aortic valve. It simulates the clinical features of a patent ductus arteriosus very closely except that the location of the murmur is atypical. An accurate differentiation between the two conditions is possible only by cardiac catheterization or retrograde aortography.

Efforts to close an aorticopulmonary defect by techniques similar to those employed for a patent

continued on next page

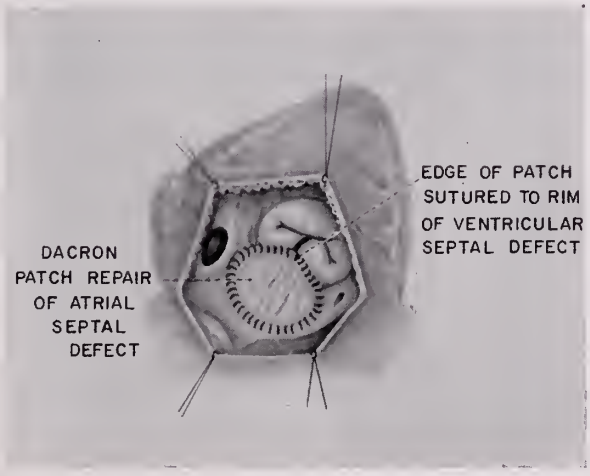


FIGURE 11c

Complete endocardial cushion defect, "Atrioventricularis Communis." Steps in the complete repair.

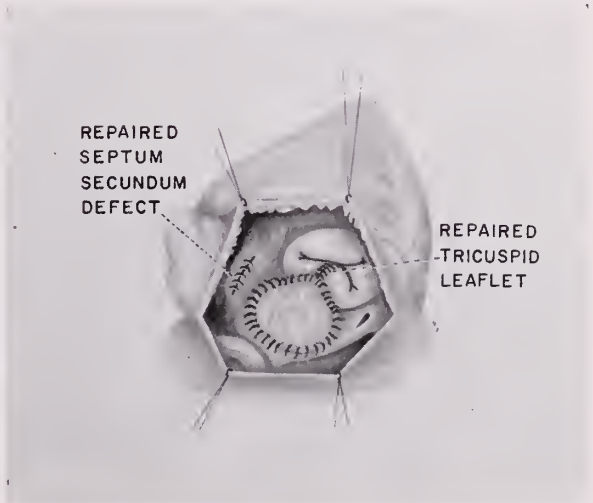


FIGURE 11d

Complete endocardial cushion defect, "Atrioventricularis Communis." Steps in the complete repair.

ductus arteriosus are difficult and hazardous. On the other hand, heart-lung bypass with an extracorporeal circulation permits an accurate closure of the defect from within the pulmonary artery at an acceptably low risk.[64]

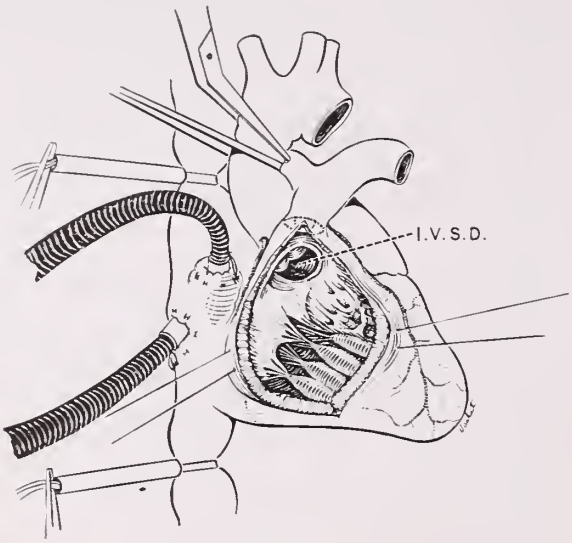


FIGURE 12a

Ventricular septal defect. Steps in surgical repair utilizing an Ivalon sponge patch.

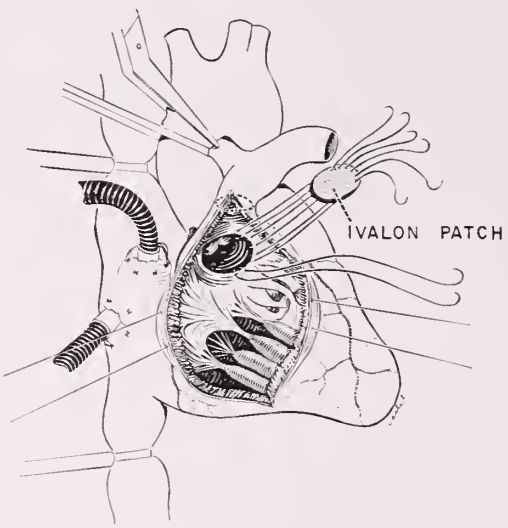


FIGURE 12b

Ventricular septal defect. Steps in surgical repair utilizing an Ivalon sponge patch.

Aneurysm of the Sinus of Valsalva

Rupture of an aneurysm of the sinus of Valsalva[65] is seen most often in adults and is characterized by the sudden occurrence of a continuous precordial murmur. Rupture occurs either into the right atrium or right ventricle. The diagnosis can readily be made by cardiac catheterization or by retrograde aortography. Operation is indicated as soon as the diagnosis is made since there is a progressive downward course in most patients following rupture of the sinus.

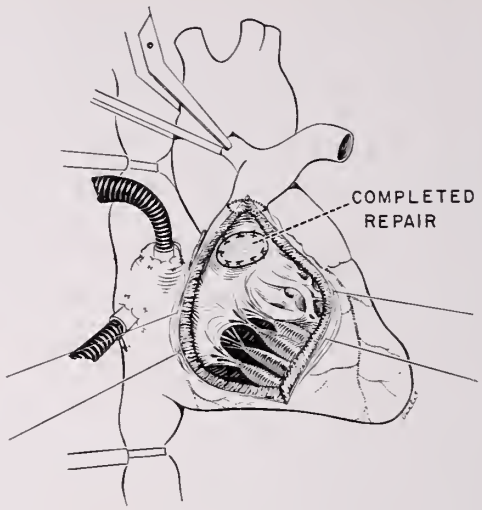


FIGURE 12c

Ventricular septal defect. Steps in surgical repair utilizing an Ivalon sponge patch.

Cardiopulmonary bypass and a right atriotomy provide optimum conditions for the repair of this lesion which must be accomplished without distortion of the aortic valve.

Tetralogy of Fallot

Tetralogy of Fallot, the most common cause of cyanosis in infancy and childhood, is now amenable to complete surgical correction. Characteristically, this condition consists of a large ventricular septal defect straddled by a dextroposed aorta, obstruction of the pulmonary outflow tract at one or more levels, and hypertrophy of the right ventricle. Physiologically, there is diminished pulmonary blood flow and a shunting of blood from the right ventricle into the aorta.

The shunting procedures of Blalock and Potts usually result in relief of cyanosis and an increase in exercise tolerance. A follow-up of cases operated upon five to ten years previously has revealed improvement in 70 per cent of the survivors.[66] Similar results are anticipated from an anastomosis between the superior vena cava and the right pulmonary artery. However, all these indirect procedures simply substitute one abnormality for another and do not correct the underlying lesion.

Systemic-pulmonary shunts are now reserved for use in small, severely-cyanotic children under two years of age. It is hoped that these palliative procedures will improve these desperately sick children and permit a definitive, complete correction at a later date. The caval-pulmonary artery shunt is employed only when severe, uncorrectible atresia of the pulmonary artery exists. In all other patients, regardless of the degree of cyanosis, an effort is made to achieve complete correction by an open

operation utilizing extracorporeal cooling and cold cardiac arrest. Figure 13 illustrates the operation employed successfully in a 23-year-old patient. While the mortality rate for this procedure was initially high, increasing experience together with advances in technique[67-70] has now lowered the risk to approximately 20 to 25 per cent. The technical ease with which the pulmonary outflow tract can be reconstructed appears to play an important role in determining risk. Thus, in the so-called "acyanotic tetralogy" where outflow obstruction is minimal, the risk approaches that for the repair of simple ventricular septal defects.

Transposition of the Great Vessels

Complete transposition of the great vessels is characterized by the aorta arising from the right ventricle and the pulmonary artery from the left ventricle. Life is possible only if there is some mixing of the two circulations via a patent foramen ovale, ductus arteriosus, or septal defect — either atrial or ventricular. Children suffering from this abnormality are intensely cyanotic and usually do not survive beyond their first six months of life. However, some patients have survived for as long as ten years.

Utilizing extracorporeal cooling and cardiac arrest, some surgeons[71-75] have successfully revised the interior of the atria so as to divert the caval blood flow into the left atrium and direct oxygenated pulmonary venous blood into the right atrium. While these efforts are attended by a very high mortality, some success has been achieved. In the light of the extremely poor prognosis without treatment, it would appear that continued attempts to help these unfortunate children are fully justified.

2. ACQUIRED CARDIAC LESIONS

Mitral Stenosis

The success achieved so far with the closed operation for the relief of mitral stenosis justifies its continued use. The addition of combined finger fracture and instrumental dilatation by Logan[76] and others[77-80] has further improved the operation. However, in certain clinical situations it is now clear that direct vision surgery is the method of choice.[81]

The presence of free or adherent clot within the left atrium or atrial appendage constitutes a hazard during an attempted closed operation. The thrombus may be dislodged or fragmented during the intracardiac manipulations resulting in serious peripheral embolization. For this reason it is now considered advisable to employ an open procedure for those patients who have a history of peripheral embolization or one suggesting the presence of an occluding atrial thrombus. With the left atrium

continued on next page

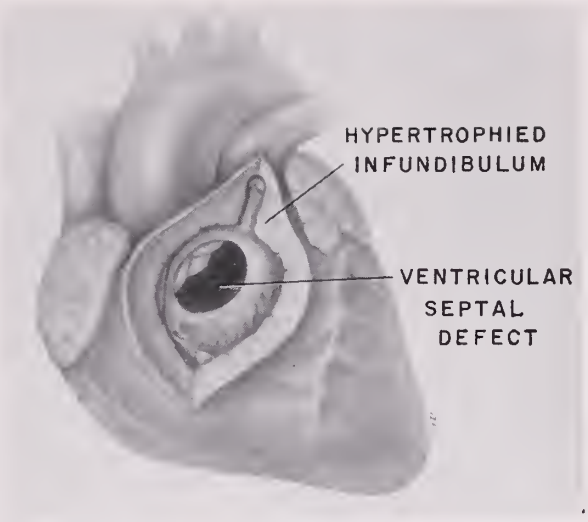


FIGURE 13a
Tetralogy of Fallot. Surgical correction.

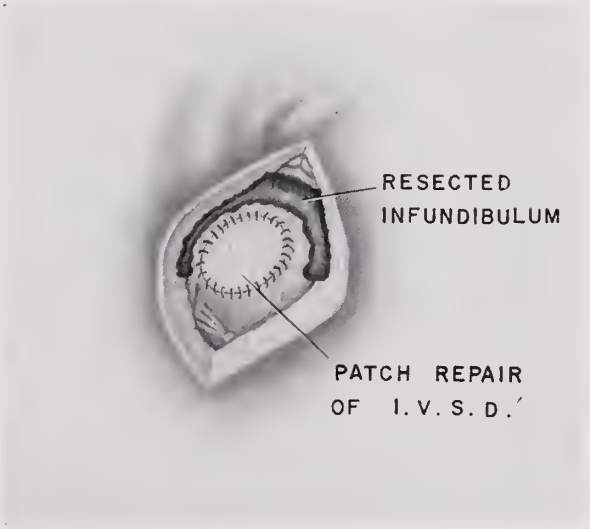


FIGURE 13b
Tetralogy of Fallot. Surgical correction.

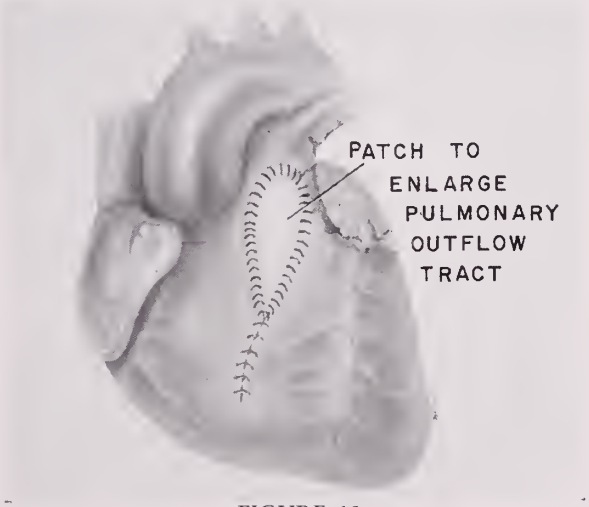


FIGURE 13c
Tetralogy of Fallot. Surgical correction.

opened and emptied of blood, gauze can be packed into the narrowed valve orifice to trap any clot fragments during the removal of the thrombus.[82]

In cases where any degree of mitral regurgitation exists, there is little justification for attempting a blind technique. The valve orifice can usually be enlarged under these circumstances, but regurgitation is frequently made worse. Under direct vision it is sometimes possible to completely open the valve and restore its competency.[83] Admittedly, these valves are frequently so badly deformed that even with an open method there is little that can be accomplished short of replacement with a suitable prosthesis.

Operation for re-stenosis is another indication for employing an open technique. Not only can a more thorough mobilization of the valve be accomplished, but the hazard of hemorrhage from tearing of the left atrium — the appendage of which has been previously resected — is avoided.

The risks of operation by either open or closed methods in far advanced (Class IV) patients are virtually the same. A pump-oxygenator, however, provides a means for sustaining the patient's circulation until an adequate valvuloplasty can be performed. We prefer to establish partial perfusion by cannulating the femoral vessels first. After stabilizing the circulation with the heart-lung machine, a thoracotomy can then be performed and a cannula introduced into the superior vena cava. Employing this technique, many patients who before might have succumbed during the blind procedure can be effectively treated.

Mitral Regurgitation

Open-heart surgery is essential for the treatment of mitral regurgitation.[84-87] An approach to the valve through the left atrium and a right thoracotomy is satisfactory. Where valvular insufficiency is largely the result of annular dilatation, repair is possible by plicating the limbs of the annulus and drawing the valve leaflets together. When a rupture of the chordae tendineae is found, the valve edge can be re-suspended. In general, a number of methods are utilized, and their choice depends upon the pathological mechanism producing the insufficiency. As was mentioned above, a satisfactory repair is sometimes impossible and a prosthetic valve must be employed.

Mitral Valve Prostheses

Because the severely-calcified mitral valve usually defies satisfactory surgical correction, several investigators[88-92] have searched for a suitable prosthesis. A number of materials and valve designs were studied in dogs by the author (Figures 14 and 15). A bicuspid teflon fabric prosthesis which functioned satisfactorily in dogs for limited periods of time was finally developed. Dissatisfaction with this valve led to the adoption of a ball-valve which had been proven successful in the laboratory and in human patients by Starr.[92,93] With this valve (Figure 16) we have been able to achieve long-term survivors in dogs (Figure 17). To date, Starr has successfully utilized a silastic, caged-ball valve in 15 patients. Nine patients have survived the procedure and are now alive from 1 to 15 months following operation. His experience together with ours in the laboratory has convinced us of the need to have such valves sterile and ready for clinical use whenever a severely-diseased mitral valve is operated upon.



FIGURE 14
Silastic rubber flutter valve.

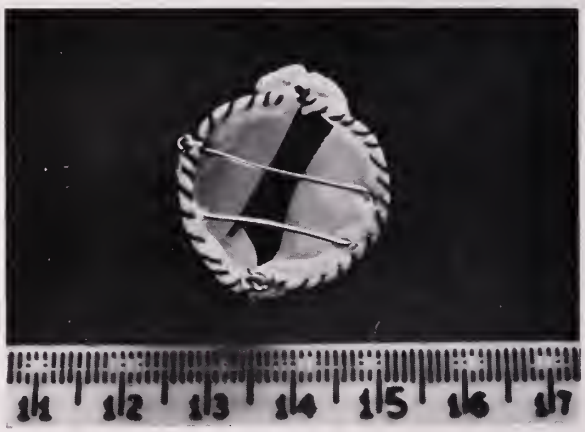


FIGURE 15
Bicuspid teflon valve.

Aortic Stenosis

Among the cardiac lesions dealt with by the cardiac surgeon, aortic stenosis has been one of the more frustrating. Poor results from blind efforts to enlarge these calcific valves have convinced most surgeons of the value of direct-vision techniques utilizing extracorporeal circulation.[94-97] This method allows a sufficient period to relieve the stenosis and

improve valvular function. We have employed profound cardiac hypothermia without coronary perfusion to effect cardiac arrest and permit access to the aortic valve through an incision at the root of the aorta.[98] The fused commissures are incised to within 1 millimeter of the annulus and calcific encrustations are carefully removed. If fragmentation occurs during removal of the calcium or if shortening of the cusp is found, plastic fabric replacement has been employed to ensure coaptation of the cusps during diastole. Nonetheless, in spite of these ingenious techniques many aortic valves, the so-called "clam shells," cannot be restored surgically. Only total valve replacement can offer any hope to patients with these far advanced lesions.

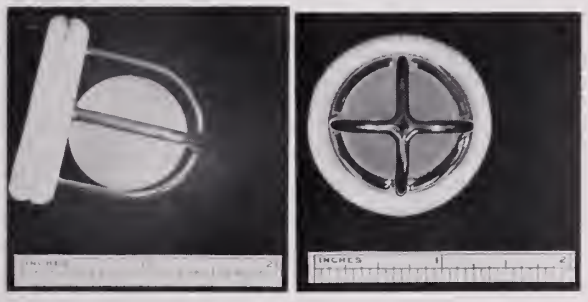


FIGURE 16

a, b. Starr-Edwards prosthesis for mitral valve.



FIGURE 17

Roentgenogram of a caged ball-valve, replacing the mitral valve of a dog, six months after implantation.

Aortic Regurgitation and Aortic Valve Replacement

Aortic insufficiency due to a prolapse or rupture of a valve cusp following subacute bacterial endocarditis is often amenable to reconstructive measures under direct vision. Re-suspension of the redundant cusp or a patch at the point of rupture will sometimes restore complete competency.[99] The author has had such a rewarding experience in a 21-year-old male (Figure 18). Garamella and his associates[100] have excised the noncoronary cusp together with a portion of the aortic wall and created a competent bicuspid valve. However, when

R.R. 21 yr. ♂

FREE AORTIC REGURGITATION

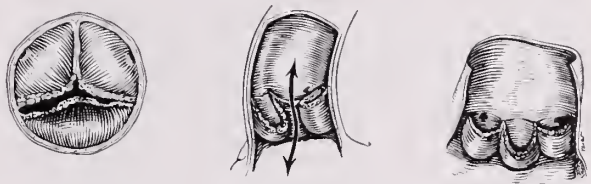


FIGURE 18a

Pathological features and repair employed in a 21-year-old male with a prolapsed aortic cusp secondary to subacute bacterial endocarditis.



FIGURE 18b

Pathological features and repair employed in a 21-year-old male with a prolapsed aortic cusp secondary to subacute bacterial endocarditis.

insufficiency is associated with calcific aortic stenosis, simple debridement of the valve is rarely sufficient to restore competency. A prosthesis appears to be the only suitable measure in these cases.

An enclosed plastic ball-valve devised by Hufnagel, when implanted in continuity with the descending thoracic aorta, proved to be of some palliative value.[101,102] With the development of improved techniques for cardiopulmonary bypass and cardiac arrest, several other prostheses have been devised.[103–107] Some of these have been employed clinically. Cusps of finely-woven teflon fabric or silicone-rubber impregnated fabric have been successfully used to partially or completely replace the diseased valve (Figure 19). A caged-ball valve implanted below the origin of the coronary arteries has been successfully employed clinically by Harken.[104] While the choice of the ideal prosthesis awaits long-term follow-up, sufficient experience has been gained to justify their use clinically in patients who currently need treatment.

Coronary Artery Disease

An enormous experimental and clinical effort has been directed toward the surgical treatment of arteriosclerotic coronary artery disease. Most of these efforts are indirect and aimed at improving myocardial blood supply. While the originators of the varied operative procedures have been encouraged by their results, the referring physicians generally have not.

concluded on next page



FIGURE 19

Prosthetic valve cusps of teflon and silastic rubber currently employed clinically.

The advent of cardiopulmonary bypass and perfusion cooling has now made possible a direct surgical attack on the occluded coronary artery. Increasing use of coronary arteriography suggests that many occlusions are localized to limited segments of the major coronary vessels. Longmire and his associates[108] and others[109–112] have successfully performed coronary endarterectomies and restored coronary blood flow. Recently, Crafoord[113] has employed strip grafting of autogenous vein to enlarge the circumference of the coronary artery after removing the obstructing process.

SUMMARY

Clinical cardiac surgery, only a little more than twenty years old in America, has progressed to include operations which once seemed impossible. Its present status has been reached through the development of physiological concepts and apparatus which have made open-heart surgery a reality. Hypothermia induced with a heat exchanger has added to the safety of extracorporeal circulation. Cardiac arrest and profound hypothermia provide a relatively dry, motionless, operative field. Under these optimum operating conditions, it is now technically possible to correct a number of complex intracardiac lesions. This progress has been so rapid that merely keeping up with events has been likened to the dilemma of the Red Queen in Alice's dream who had to run as fast as she could only to stay in the same place.

REFERENCES

A complete list of the references of the Fiske Essay on the *Current Status of Cardiac Surgery* will be furnished on request to this journal.



Wherever you go forget your telephone calls. We'll take them for you, day or night.

MEDICAL BUREAU

of the

Providence Medical Association

Editorials

THE FISKE FUND PRIZE ESSAY

PUBLISHED ELSEWHERE in this issue is the winning essay on the 1961 question *Current Status of Open Heart Surgery* by Doctor Lester L. Vargas, Chief of the Department of Surgery at the Rhode Island Hospital. Rather than review its contents, we urge our readers to peruse the paper. They will find it rewarding, as it is an excellent and lucid exposition of the status of this interesting, important, and highly technical specialty. We congratulate our colleague for returning the prize to Rhode Island with a polished and professional contribution.

The prize, established in the will of the late Doctor Caleb Fiske, was first awarded in 1835. It is one of the oldest medical prize competitions in America. Over the years there have been contributors from far and wide. In 1854 the prize went to a Londoner, the only foreign contributor we believe. In recent years the prize has gone as far afield as Seattle, Washington. We welcome Doctor Vargas to the long list of winners, and to the shorter, but no less distinguished list of Rhode Islanders who have won the prize.

BOATING AND BOATING HAZARDS

THIS IS THE TIME of year when everyone who owns a boat, whether it be outboard, inboard, or sail, is putting on the finishing touches of paint, preparatory to a summer of fun. Others are shopping around to buy a boat. People who would ordinarily use caution in learning to drive a car, and spend a great deal of time studying the rules of the road, think nothing of buying a high powered boat and taking it into deep water without bothering to learn basic operating rules, charts, and weather. They are not only gambling with their own lives, but are also jeopardizing the lives of any passengers foolhardy enough to go with them. There is no law to stop them. Anyone can buy a boat, and no driver's examination or pilot's license is required for pleasure craft.

Here in Rhode Island we have one of the finest stretches of water in the country for bay and blue water sailing. There are many marinas all along the bay shore where one can get service or a mooring. The bay is also dotted with numerous islands most of which have a sheltered cove where one can anchor with safety. For deep water sailing it is only a comparatively short run to Block Island Sound. All this wealth of natural resources has also brought its problems. A recent article in the Sunday NEW YORK TIMES stated that there are over 7,000,000 pleasure boats in the country. The Coast Guard safety experts are seriously concerned. They don't have the manpower or the floating equipment to chase down all violators, or the anticipated number of missing boatmen.

Boating knowledge just doesn't come to a man. It has to be learned and then practiced. The more know-how a man has about boating, the more fun it is. Without know-how it is usually uncomfortable, sometimes it can be dangerous, and always it is foolish. The means of acquiring boating knowledge are readily available. The United States Power Squadrons, the Coast Guard Auxiliary, and some local marinas offer courses in seamanship and small boat handling. The Narragansett Bay Power Squadron offers these courses free of charge. Classes start in the fall at Brown University and usually meet on a Monday evening. As one masters the basic knowledge, one can continue on with more advanced courses. One of the finest books written for the novice, and even for the experienced boatman, is called PILOTING, SEAMANSHIP, AND SMALL BOAT HANDLING by Charles F. Chapman. This book is available at all marine stores and is a must. It would take the average man a lifetime of boating to learn all that is packed into this one volume.

This is also the time of year when the Coast Guard Auxiliary offers the benefit of courtesy examinations of boats. Any boat displaying the C.G.A. SEAL OF SAFETY indicates that it has been inspected and has all the approved equipment required for safe operation.

continued on next page

It is not our purpose to list all the do's and don'ts of safe boating practices, nor list all the equipment necessary for any class of boat. This information is readily available to anyone interested. Rather it is a plea for caution and common sense. Don't overload; be sure there is a life preserver for everyone aboard; don't overlook an adequate first aid kit; and don't venture off shore unless you know how to plot a course and have the latest weather information. Courtesy is another commodity lacking in many boating enthusiasts. This is usually the result of lack of knowledge or experience. With dozens of vessels lying at anchor in a harbor, it is a common sight to see a water skier threading in and out like a giant slalom. The high speed necessary to pull the skier creates a wake that will rock even the larger boats so that hot liquids may be spilled, equipment broken, or serious injury result to the unfortunate unprepared for the sudden lurch. Let us use a little courtesy and common sense — and keep our accidents to a minimum.

DEAR NIH:

THE TERM PROTOCOL commonly refers to the rules or code prescribing etiquette in diplomatic or state functions with reference to rank or title. The word has another meaning, however, less well known to the common herd, namely: "An official statement or account of a proceeding, as a description of an experiment or a clinical report." This species of protocol is dear to the hearts of professional researchers — it has something to do with the procurement of research grants. Professor Norbert I. Hammerschlager, that whimsical old codger known affectionately to many generations of medical residents as "that old N.I.H.," has commented in characteristically elegant prose: "There's plenty of dough around, if you know how to write a protocol." Protocol is derived from the Greek *protos* (meaning "first") and *kolla* (meaning "glue"), "which," says Professor Hammerschlager in a bantering mood, "makes it a rather sticky business, don't you know." The professor has recently run up a protocol which he estimates "should be worth about 8,000 bucks":

The Sex Life of the Female Shrew

Definitions: The shrew is a small mammal, mouselike and chiefly nocturnal, which feeds on worms and insects. That is, the male shrew is mouselike and nocturnal and feeds on worms and insects. The female shrew is a horse of a different color (no joke intended), being "vexatious, perverse, turbulent, scolding, brawling," and occasionally bawdy. The female shrew feeds on steak and lobster in broad daylight. The shrew has a pointed snout which gets into everything and very small beady eyes.

Objectives: The purpose of this investigation will be a study in depth of the sex life of the female shrew. The degree of depth will depend upon a feasibility determination, as well as the availability of moolah. Moolah is the life-blood of female shrews and also of grantz. The study will attempt a longitudinal evaluation of the female shrew in the horizontal position, both in the presence and absence of that mouselike and chiefly nocturnal mammal. In case this objective is not finalized, a secondary target will be the transverse evaluation in the vertical position.

Methods: The methodology of the parameters will be analagous to the Kinsey report, but a different species of shrews will be surveyed. Questionnaires will be sent to all female shrews, in six languages, including Bantu, and the data will be placed on IBM punch cards for later analysis. IBM stands for inboard motor, which contrasts strikingly with the outboard motor, particularly as concerns free board, room and laundry. The data will then be programed and scored for three French horns and a piccolo, and finally processed in a computer, like a fine old cheese. Determination of the number of female shrews playing the piccolo will be extremely valuable to later investigators.

Staffing and Equipment: In addition to the senior investigator (dear old Hammerschlager, no less), there will be three research associates (male shrews, chiefly nocturnal), two stenographers (female shrews), and a diener named Archie. Chemicals (flea powder), stationery, and light bulbs will be required in moderate amounts. The cost estimate includes one room air-conditioner for the senior investigator. Overhead, with adequate ceiling clearance for investigators of varying stature and build, will amount to an additional fifteen per cent.

The total cost of the investigation for one year will be $8,112.32, including Blue Cross and Blue Shield.

Invest in the future health of the nation and your profession

Give to medical education through AMEF

American Medical Education Foundation AMEF 535 N. Dearborn St. Chicago 10, Ill.

Registration
is open to all PHYSICIANS

"YOUR STAKE IN DISABILITY DETERMINATION"

A postgraduate course in measuring capacity to work

Sponsored by

- **Rhode Island Medical Society**
- **Rhode Island Division of Vocational Rehabilitation**
- **The Medical Advisory Committee to the Social Security disability program**

WEDNESDAY, SEPTEMBER 19, 1962
10:30 A.M. to 5:00 P.M.

COLONY MOTOR HOTEL, CRANSTON
LUNCHEON WILL BE SERVED

The facilities of the Marco Polo Lounge will be available for a social hour at the close of the seminar.

ADVANCE REGISTRATION

TEAR HERE

TEAR HERE

To
Rhode Island Medical Society Seminar Committee
106 Francis Street
Providence 3, Rhode Island

Yes, I will attend the Seminar on September 19 at the Colony Motor Hotel ☐

Yes, I wish to be included for luncheon. ☐

NAME

ADDRESS

ANY OF THESE COULD BE YOUR PATIENT.
ARE THEY TOTALLY AND PERMANENTLY DISABLED

This former machinist hasn't worked since a January 1959 accident in which he fractured his right ulna and lacerated the dorsal surface of his right hand, partially severing the extensor tendons. Nonunion of the ulnar fracture segments persists. The arm is markedly deformed and atrophied. Patient cannot make a fist.

Noticed difficulty breathing in 194 which kept getting worse. Examined a clinic June 1945 and told he had emphysema. Advised to avoid upper respiratory infections. In June 1962, walking block completely exhausts him. Physical examination in June 1962 showed breath sounds absent throughout most of chest with expiratory wheezes, chest emphysematous, coarse expiratory rales. Chest X-ray revealed flattening of diaphragms, widened rib spaces, markedly decreased bronchovascular markings throughout.

This man worked steadily until June 4, 1961, when, while working on his farm, he experienced an episode of severe unremitting chest pain. He was hospitalized with a diagnosis of acute anterior myocardial infarction. Current medication consists of digitalis, coumadin and nitroglycerin. He experiences S.O.B. and angina on walking two blocks.

After 20 years as office clerk, S.K. stopped working because of nervousness, irritability and forgetfulness. Says he is jittery, has rare dizzy spells, generally feels tired and is easily afraid. He keeps busy reading but forgets what he reads. Tremors in head and extremities, memory poor both for past and recent events.

TEAR HERE

Rhode Island Medical Society Seminar Committee

106 Francis Street

Providence 3, Rhode Island

TEAR HERE

PHYSICIANS!

Register Now . . .

MAIL THIS CARD TODAY.

SWIMMING POOLS

SEVERAL MILLION AMERICANS will do most of their swimming this summer in their own pools or in the pools of friends or neighbors. In the past ten years the number of home swimming pools in the United States has increased to the substantial total of 150,000. To this number can be added almost one million plastic play pools which have become so popular with small fry. Water is always an attractive nuisance to little children. Swimming pools may furnish much cooling comfort and family-style relaxation, yet can be a source of danger as well as pleasure in the nation's backyards. Swimming pools are like big tubs in which many people take a bath in the same water. Among their serious hazards are staphylococcus infections, impetigo, otitis media, broken necks, and certainly, not least of all, drowning. Drownings in swimming pools are reported each year in increasing numbers. What can be done to reduce these hazards?

The Rhode Island State Department of Health will furnish upon request a copy of *Swimming Pool Law: Rules and Regulations.* Its Division of Sanitary Engineering is ready to advise anyone having a swimming pool concerning the best methods for maintaining it in sanitary condition.

Know the pool in which you are swimming. A safe pool is situated near the house, permitting a continuous view of the youngsters' activities. Fence in the pool or the whole area in which it is located. Use a good lock on the gate. Have suitable supervision for the children. Keep life-saving rings, pillow, ropes, or a reaching pole handy at all times. Light the pool area well if evening use is allowed. Check walkways, deck areas, and springboards for dangerous conditions, such as slipperiness or splintered boards. Mark water depths clearly and separate shallow and deep areas by a rope and buoys. Make sure all pool users know how to swim.

A safe pool is a clean pool. The swimming water should test as pure as tap water. The pool should have water at one end for timid bathers, or beginners, and water of sufficient depth at the other end to permit a person to dive without danger of striking the bottom. The "Bathing Load" of a swimming pool is as important as its design. It must have a capacity in gallons of water proportionate to the number of bathers which it is expected to serve.

There are few lucky enough to have a clean brook running through the pool. Most owners have to keep the water safe by one of the two following methods. The fill-and-draw system, although cheaper to start with, is more costly in water consumption; and it is harder to keep the water pure since impurities build up, and frequent refills are needed. Unless, therefore, a practically inexhaustible supply of water is available at low cost, the continuous recirculation plan with filters and pumps is much more practical. The type of filters used should be carefully selected to ensure proper purification and ease of operation, and the filters, circulation pumps, and piping systems should be of sufficient capacity to provide for any emergency. Chemical conditioners are added to the water in both methods.

No one should expect mechanical water cleaners to do the impossible. Foreign material and objects should be kept out of the water. All bathers should use toilet and showers before entering the pool. Anyone with signs of skin or eye infections, colds, and ear or nasal discharges should stay out of the water.

A regular pool schedule may be posted, and supervision provided during the periods of use. Instructions on the arm-lift, back pressure method of artificial respiration as recommended by the American National Red Cross, and a swimming pool safety check list with tips for the swimmers prominently displayed will remind swimmers to take precautions for their own safety and that of the others. A properly equipped and supervised pool means enjoyment and a happy summer in the water.

E. P. ANTHONY, INC.
Druggists
WILBUR E. JOHNSTON, Phar. D.
RAYMOND E. JOHNSTON, B.S.
178 ANGELL STREET
PROVIDENCE, R. I.
GAspee 1-2512
Pharmacy License #225

J. E. BRENNAN & COMPANY
Leo C. Clark, Jr., B.S., Reg. Pharm.
Apothecaries
Two Convenient Locations
5 North Union Street Pawtucket, R. I.
140 Central Avenue Seekonk, Mass.
7 Registered Pharmacists
Pharmacy License #226

ACUTE RENAL FAILURE COMPLICATING SALICYLATE INTOXICATION: ROLE OF THE ARTIFICIAL KIDNEY

A Case Report

JOHN B. LAWLOR, M.D.; ROGER G. BERARD, M.D., AND ERNEST K. LANDSTEINER, M.D.

The Authors. *John B. Lawlor, M.D., Junior Assistant Surgeon, Department of Urology, Rhode Island Hospital.*

Roger G. Berard, M.D., formerly Senior Resident, Department of Urology, Rhode Island Hospital.

Ernest K. Landsteiner, M.D., Surgeon-in-chief, Department of Urology, Rhode Island Hospital.

THE WIDESPREAD USE and easy availability of salicylates has inevitably led to frequent instances of poisoning due to overdosage. In fact these medications account for over four per cent of all fatal poisonings due to drugs in this country.[1]

Artificial kidney hemodialysis as an adjunct to usual medical therapy in the management of such cases of severe poisoning has greatly increased their chances of survival. The use of hemodialysis was first proposed by Doolan in 1951.[2] According to the literature since then, eleven patients have now been so treated,[3-7] the first successfully by Schreiner[3] in 1955.

The nephrotoxic effect of salicylate drugs is well known.[2,8] In the early group of patients reported to have been treated for acute salicylism with the artificial kidney, none who developed subsequent acute renal failure survived. However, a report by Segar and Holliday[9] includes a two and one-half-year-old patient who successfully underwent peritoneal dialysis for this complication of salicylism. The purpose of this paper is to present the interesting case of a patient who exhibited, after dialysis for salicylate intoxication, the classical syndrome of acute tubular necrosis, but then recovered in response to conservative management, without resort to a second dialysis.

Case Report

M. S. (R.I.H. 623541), an unemployed white male, age 52, was admitted to the Rhode Island Hospital on September 30, 1959, because of fever, profuse perspiration, and vomiting of several hours' duration. He had been well until his father's death one month prior to admission when, according to his family, he had become withdrawn and negativistic. Past history was otherwise not contributory. Physical examination revealed a temperature of 104.6 rectally, pulse of 132, respirations of 36 per minute, and arterial blood pressure of 120 80. The patient was a well-developed, somewhat obese white male perspiring profusely, tachypneic and markedly lethargic, responding only to commands. Neurological examination revealed no nuchal rigidity and no pathological reflexes. Examination of the stool showed a two plus benzidine reaction. Urinalysis revealed slightly cloudy gross appearance, a pH of 5, two plus protein, no glucose, and a moderate sediment containing 10 to 15 red blood cells, 0 to 3 white blood cells and occasional coarse, granular casts. The hemoglobin was 17.0 gm. per 100 ml., and the hematocrit 47 per cent. The white-cell count was 29,000 with the following differential: 88 per cent neutrophils, 10 per cent lymphocytes, 2 per cent monocytes. Blood urea nitrogen was 17 mgm. per 100 ml., fasting blood glucose was 160 mgm. per 100 ml., and the blood carbon dioxide combining power was 16 millieq. per liter.

At first, the patient was thought to be suffering from some type of acute infection. He was unable to give a clear history, and the psychiatric information was not elicited until the patient's family was interviewed the day after admission.

In spite of receiving adequate parenteral fluids, he was noted to be oliguric the morning following admission. The blood urea nitrogen had risen to 44 mgm. per cent, and the creatinine to 4.5 mgm. per cent. His temperature remained elevated between 103 and 106° F. On the next day the blood pressure had fallen to 70 40, and it was necessary to administer parenteral vasopressors. In addition he was now completely unresponsive. By the morning of the third day the blood urea nitrogen had risen to 96 mgm. per cent with a creatinine of 8.4 mgm. per cent. Serum electrolytes were normal, as were febrile and cold agglutinins, and the eosinophile count.

When the patient's recent emotional depression came to light, his room was searched and an empty aspirin bottle was found. This had contained 300 five-grain tablets (96 grams) of aspirin, all of which the patient later admitted taking.

A blood salicylate level was 68 mgm. per cent, and a urine ferric chloride test was strongly positive.

In view of the now clearly established diagnosis of salicylate poisoning and the patient's rapidly deteriorating clinical condition, we decided to use artificial kidney dialysis. This was done using a Kolff twin-coil artificial kidney for a period of six hours. During this procedure his elevated temperature returned to normal, he became responsive, and his blood pressure rose to 120/80 without the use of vasopressors. This dramatic clinical improvement continued after dialysis even though severe oliguria persisted for a total of 12 more days (Chart 1). During this period his fluid intake was carefully restricted and adequate calories administered as carbohydrate. His blood urea nitrogen rose to a high of 268 mg. per cent and the serum potassium to 7.2 mEq. per L. Diuresis started just before a second dialysis became necessary, and its progress was uneventful. The patient's subsequent recovery was interrupted by an acute myocardial infarct on the thirty-third hospital day, but he responded to medical management, and was then transferred to the Rhode Island State Hospital for Mental Diseases, to be further treated for schizophrenia.

Discussion

It is interesting to note that, although the artificial kidney has been a practical mode of management for acute salicylism for only six years, salicylates were dialyzed from the blood of experimental animals by Abel, Rowntree and Turner[10] in 1913. In the years since this pioneer work was done the ease of obtaining and administering aspirin has made it one of the common agents for attempted suicide. Furthermore, salicylates, especially pleasant tasting ones, are now among the more frequent causes of accidental poisoning in small children. In Arena's report[11] of 834 deaths from accidental poisoning in children under five, 14 per cent were attributed to salicylism. Methyl salicylate (oil of wintergreen) is especially dangerous because of its fragrance and the ease with which a large dose can be ingested.

The case here reported illustrates two distinct clinical syndromes, occurring simultaneously as a result of a usually lethal (suicidal) dose of aspirin. Both of these represent disturbances amenable to hemodialysis. The first, acute salicylism, with respiratory and circulatory collapse, was treated successfully by dialysis with the Kolff twin-coil kidney. The second, acute renal failure resulting in oliguria for twelve days during the post-dialysis period, was managed conservatively. The classical syndrome of acute tubular necrosis resulting from salicylism, and characterized by oliguria, hyperkalemia, and azotemia, followed by a diuretic phase, is a feature of the disease which, to our knowledge, has not previously been reported with complete recovery.

SUMMARY

Severe acute salicylate poisoning responds favorably to early dialysis with the artificial kidney. Subsequent renal failure caused by the nephrotoxic effect of salicylates, although it occurs but rarely, is a grave complication with a poor prognosis. A case of acute salicylism complicated by oliguric renal failure with complete recovery is therefore reported.

References

[1]Winters, R. W.: Salicylate intoxication in infants and children, Gen. Practitioner 10:67, 1954

[2]Doolan, P. D.; Walsh, W. P.; Kyle, L. H., and Wishinsky, H.: Acetylsalicylic acid intoxication: A proposed method of treatment. J.A.M.A. 146:105, 1951

[3]Schreiner, G. E.; Berman, L. B.; Griffin, J., and Feys, J.: Specific therapy for salicylism. New Eng. J. Med. 253: 213, 1955

[4]Schreiner, G. E.: The role of hemodialysis (artificial kidney) in acute poisoning. A.M.A. Arch. Int. Med. 102: 896, 1958

[5]Leonards, J.: Use of artificial kidney for purposes other than treatment of uremia. Trans. Amer. Soc. for Artificial Internal Organs 1:46, 1955

[6]Burns, R. O.; Daniel, J. M.; Jackson, H., and West, W. O.: Salicylate intoxication treated with artificial kidney. West Virginia Med. J. 54:198, 1958

[7]Thomsen, A. C., and Dalgard, O. Z.: Hemodialysis in acute acetylsalicylic acid poisoning. Am. J. Med. 25:484, 1958

[8]Krasnoff, S. O., and Bernstein, M.: Acetylsalicylic acid poisoning. J.A.M.A. 135:712, 1947

concluded on page 370

CHART I.

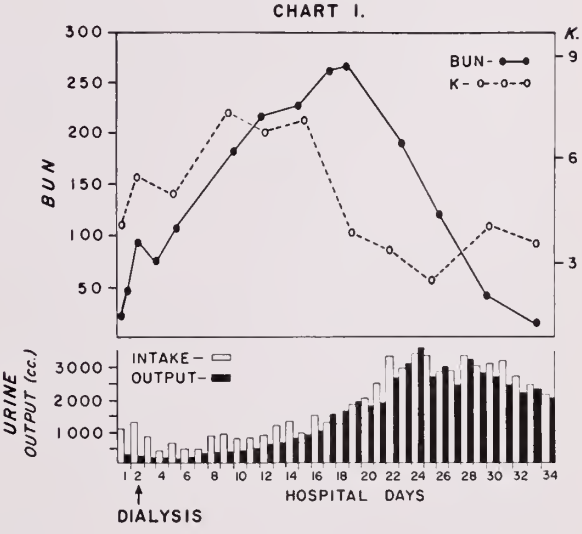


CHART 1

Graph depicting hospital course of patient with acute salicylate intoxication, showing oliguric and biochemical abnormalities. Dialysis performed for relief of progressive clinical deterioration due to acute salicylism.

PRIMARY ALDOSTERONISM

Report of a Case

DANIEL S. LIANG, M.D.

The Author. *Daniel S. Liang, M.D., Urologist, Our Lady of Fatima Hospital, North Providence, Rhode Island.*

SIMPSON AND TAIT,[1] in 1952 first detected an adrenal hormone causing sodium retention and potassium diuresis. Farrell and Richards[2] then identified it as the 18-aldehyde of corticosterone, namely aldosterone. Conn,[3] in 1955 first described the syndrome of primary aldosteronism. Since then, approximately 150 cases have been documented. We wish to report a case of a young man who was first referred for albuminuria and hypertension, emphasizing the importance of detailed studies in these cases to determine the causes of hypertension and albuminuria.

A twenty-two-year-old white male was admitted on September 18, 1961, with a chief complaint of high blood pressure and albuminuria of one and one-half years duration. He had had a complete physical examination three years before, when he was inducted into military service. At that time his urine and blood pressure were normal. One and a half years later another physical examination revealed a blood pressure of 240/140. He was found also to have a 4-plus albuminuria. He apparently had no other symptoms. There was no polyuria, dysuria, thirst, or muscle weakness. Recently, he complained of severe frontal headaches, especially in the morning. His appetite was good and there was no loss of weight.

Physical examination revealed a well-built, well-nourished, white male. There was no edema of the hands or legs. There was no distention of neck veins. Lungs were clear to auscultation and percussion. The heart was not enlarged. The abdomen was soft, nontender. No abnormal masses palpable. Kidney, liver and spleen were not palpable. On admission, the patient's temperature was 99° F, pulse 80, the respirations 20, and blood pressure 220/140.

Laboratory Findings

The urine was clear. The specific gravity was 1.009. There was a slight trace of albumin and occasional white cells; no red blood corpuscles. Hemoglobin 12.4 grams; hematocrit 37 per cent; white blood count 6,200 with a normal differential. The fasting blood sugar was 95 mg. per cent; urea nitrogen 19 mg. per cent; total cholesterol 172; CO_2 combining power 70 per cent; chlorides 120 mEq; potassium was 3.2 mEq; and sodium 157 mEq.

An intravenous excretory urogram was done showing both kidneys to be in normal position and the calyceal pattern to be within normal limits. Postvoiding films show no significant vesicle residue. Basal metabolic rate minus 8 per cent. Vanillin-Mandelic Acid test (VMA) was done showing 1.2 R values; normal is approximately 1.2 R values. Because of these findings, the question of aldosterone tumor was entertained. Although renal hypertension could not be ruled out, a translumbar aortography was done. It showed no evidence of arterial obstruction or irregularity, and there was prompt arterial flow into both patent limbs of the common iliac arteries and also the renal arteries. A retroperitoneal carbon dioxide insufflation, combined with laminography, showed the left kidney to lie at the same level as the right kidney, and on all views there was a suspicion of an enlargement of the left adrenal gland. A 24-hour aldosterone excretion study was done, showing 28 micrograms per 24 hours. An electrocardiogram showed T waves to be sharply inverted, and the conclusion was injury pattern, probably old myocardial infarct. Because of the findings of low potassium, high sodium, enlarged left adrenal in the retroperitoneal carbon dioxide insufflation, and the increase in aldosterone in the urine, a definite diagnosis of aldosterone tumor of the left adrenal gland was made.

Clinical Course

A left adrenalectomy was performed on 10/2/61, with removal of a tumor approximately 2 cm. in greatest diameter oval shaped. The post-operative course of the patient was uneventful. The blood pressure remained high, 210/140, and fluctuating, until 10/3 when it dropped to 160/120. On the day of discharge the blood pressure was 160/90. The post-operative chemistry showed CO_2 combining

capacity to be 56 volume per cent. The chlorides were 104 mEq, potassium 5.7 mEq, and sodium 144 mEq. The urea nitrogen had risen to 40 mg. per cent. The urinalysis showed a specific gravity of 1.015, slight trace of albumin. Occasional white and red cells.

Pathological Findings

The largest of the fragments of tissue received showed an ovoid, somewhat flattened tumor measuring 1.8 x 1.5 cm. The tumor was sharply demarcated and composed of cortical parenchyma displaying on sections somewhat soft, but rather compact, orange-yellow tissue with minute cystic cavities about the central portion of the mass. The medullary portion of the gland was minimal in amount and appeared compressed by cortical tumor. The capsule of the adrenal gland, which also enveloped the tumor, was very fine, transparent, and intact, with no gross evidence of invasion.

On microscopic section the adrenal gland revealed a nodular tumor in the substance of the cortex. The tumor was completely surrounded by a very thin, fibrous pseudo-capsule. The structure was somewhat lobulated with islands of large, clear, lipid laden cells separated by strands of fibrous tissue with areas of scarring and hyalinization. Foci of small hyperchromatic cells were present in many areas. The tumor cells displayed marked lipid depletion corresponding to 3 plus by the Currie and Symington scoring method.

Of the three cortical zones, the zona glomerulosa appeared to be the most reduced in size, with marked pseudo-tumules and atrophy. The zona fasciculata and the reticularis, except for lipid depletion, were found to be within normal size. The medulla was quite normal. Diagnosis: Cortico-adrenal adenoma.

Discussion

The term "essential hypertension" has been gradually narrowed as more causes have been found. The adrenal gland was found to be a more frequent cause of hypertension than formerly realized. Since Conn described the syndrome of primary aldosteronism, more and more cases have been reported recently. According to Conn, approximately 85 per cent of cases of hypertension are due to adenomas of the adrenal gland, 9 per cent to bilateral adrenal hyperplasia, and an occasional one due to adrenal cortical carcinoma. In the adult, adenoma is the main cause, since bilateral hyperplasia occurs mostly in children and in young adults. Conn[4] defines this as a syndrome of mineralocorticoid excess induced by excessive quantities of aldosterone. His description of this was classical.

It is felt that awareness by the physician is of prime importance. All young patients with hypertension should have a routine serum potassium, sodium, and CO_2 content determinations together with an intravenous excretory urogram. Most cases show electrocardiographic changes consistent with hypokalemia. This substantiates the low serum potassium. Pre-sacral pneumography frequently demonstrates a tumor mass, although in our case, this was covered by a small retroperitoneal hematoma as a result of the translumbar aortography. Aldosterone assay on the urine is a specific test; any elevation is considered diagnostic. It is felt that in all suspicious cases, the adrenal gland should be explored. No extra-adrenal lesions have been reported to date.[5] The kidney in primary aldosteronism shows a renal defect in tubular reabsorption of water and is resistant to vasopressin. This is due to chronic depletion of body potassium in the renal structure.[4] Various degrees of arteriosclerosis are observed. In our case it is severe. In long standing cases, a variable degree of irreversible damage may be present, but much of the tubular damage may be reversed by potassium repletion. The continued elevation of the blood urea nitrogen case may be due to a certain amount of arteriosclerosis; but it also may, according to Brill et al,[6] be due to sodium balance attained by a mechanism which is the reverse of the escape mechanism. This probably involves excessive reabsorption of the fluid in the proximal tubules, as appears to happen in cirrhotic with ascites, causing excessive reabsorption of the urea. Some of the apparent decrease in renal function which occurs after removal of aldosterone-secreting tumors might be explained by this mechanism. If this is true, then eventually the blood urea nitrogen will come down to normal. In our case, three months postoperatively, the blood urea nitrogen remained at 40 mg. per cent, but the patient was doing well, and the electrolytes had remained normal.

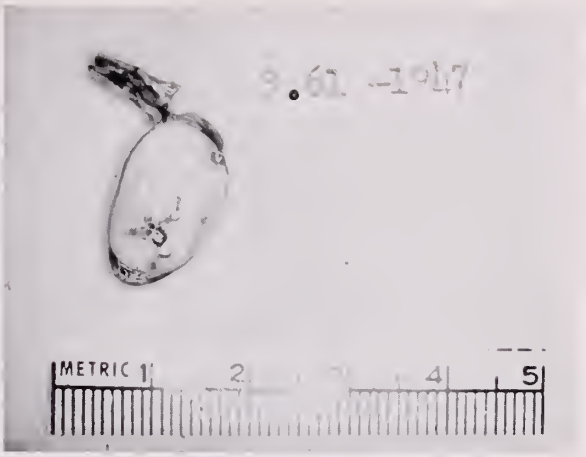


FIGURE 1
Cut section of the tumor with normal adrenal shown at top.

concluded on next page

AS CLEAN
AS MODERN
DAIRY SCIENCE
CAN MAKE IT...





The A. B. Munroe Dairy Laboratory, where milk is subjected to constant testing, using the most modern methods of milk analysis.

Through every step in processing, from the immaculate receiving room to pasteurizing and homogenizing, on through bottling and refrigeration, the A. B. Munroe Dairy observes the strictest standards of dairy hygiene. The spotless surroundings and rigid quality control are so designed that all A. B. Munroe Dairy products that reach your table are as fresh, wholesome and pure as modern science can make them.

RHODE ISLAND QUALITY MILK ASSOCIATION MEMBER

A. B. MUNROE DAIRY, INC.
151 Brow Street, East Providence, Rhode Island

Call GE 8-4450
for Home Delivery

SUMMARY

A case of primary aldosteronism is reported. The presenting features being hypertension and albuminuria without any other symptoms. A brief discussion as to the diagnosis of aldosteronism is made.

Acknowledgment

We wish to thank SALVATORE R. ALLEGRA, M.D., for taking the photograph in this case.

BIBLIOGRAPHY

[1]Simpson, S. A., and Tait, J. F.: A Quantitative Method for Bioassay of Effect of Adrenal Cortical Steroids in Mineral Metabolism. Endocrinology, 50:150, 1952

[2]Farrell, G. L., and Richards: Isolation of Potent Sodium-retaining Substances from Adrenal Venous Blood of Dog. Proceedings of Soc. for Experimental Biology and Medicine, 83:628, 1953

[3]Conn, J. W.: Presidential Address. II. Primary Aldosteronism, a New Clinical Syndrome. J. Lab. Clin. Med., 45:6, 1955

[4]Conn, J. W.: Evolution of Primary Aldosteronism as a Highly Specific Clinical Entity. JAMA, 172:1650, 1960

[5]Skause, B.; Moller, F.; Gydell, K.; Johansson, S., and Wolff, H. B.: Observations of Primary Aldosteronism. Acta. Med. Scand., 158:181, 1957

[6]Brill, G. C.; Creamer, B.; Mills, I. V., and Pullan, J. M.: Hyperaldosteronism — report of a case. Brit. Med. J., 2:990, 1960

DID YOU KNOW?

- That in the first 13 weeks of 1962 there has been some 171,000 cases of measles reported in the United States, according to the U. S. Public Health Service.
- That this is some 20,000 more cases than were reported in the first quarter of 1961, and some 4,000 cases above the median figure for 1957-1961.
- That the incidence of most other diseases is down this year, including hepatitis which fell from 23,000 cases in the first 13 weeks of 1961 to 18,000 cases for the same period this year.
- That the number of polio cases has dropped from 103 to 76; that strep throats and scarlet fever have fallen from 124,000 to 115,000; and that diphtheria went from 200 down to 134.

ACUTE RENAL FAILURE COMPLICATING SALICYLATE INTOXICATION

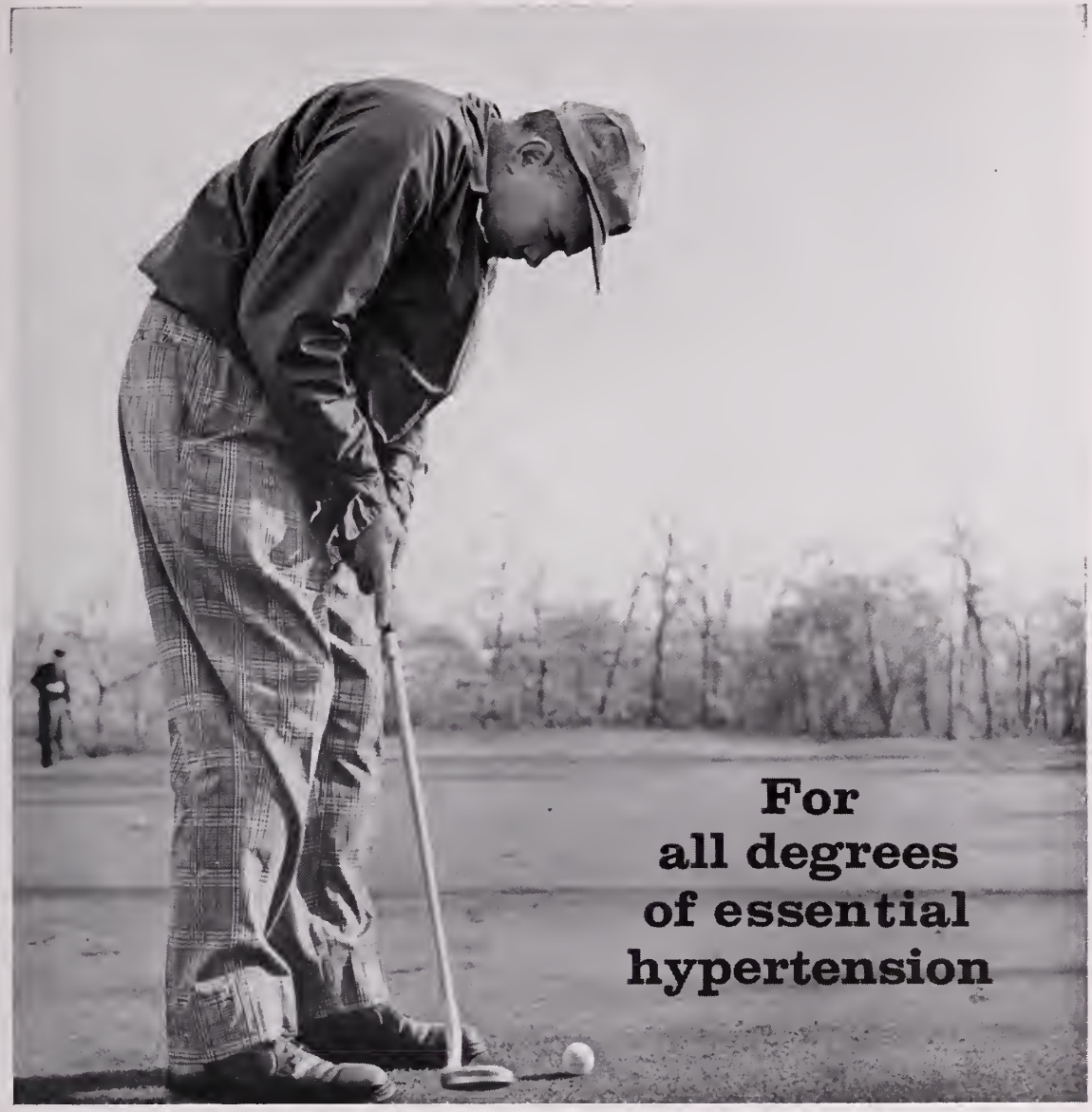
concluded from page 367

[9]Segar, W. E., and Holliday, M. A.: Physiologic abnormalities of salicylate intoxication. New Eng. J. Med. 259: 1191, 1958

[10]Abel, J. J.; Rowntree, L. G., and Turner, B. B.: The removal of diffusible substances from the circulating blood of living animals by dialysis. J. Pharmacol. & Exper. Therap. 5:275, 1913-14

[11]Arena, J. M.: The problem of accidental poisoning in children as it exists today. J.A.M.A. 159:1537, 1955

[12]Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics: a textbook of pharmacology, toxicology and therapeutics for physicians and medical students. New York: Macmillan, 1955, pp. 294-297



"relief of symptoms is striking with Rautrax-N"†

Rautrax-N decreases blood pressure for almost all patients with mild, moderate or severe essential hypertension. Rautrax-N also offers a new sense of relaxation and well-being in hypertension complicated by anxiety and tension. And in essential hypertension with edema and/or congestive heart failure, Rautrax-N achieves diuresis of sodium and chloride with minimal effects on potassium and other electrolytes.

Rautrax-N combines Raudixin (antihypertensive-tranquilizer) with Naturetin c̄ K (antihypertensive-diuretic) for greater antihypertensive effect and greater effectiveness in relief of hypertensive symptoms than produced by either component alone. Rautrax-N is also flexible (may be prescribed in place of Raudixin or Naturetin c̄ K) and economical (only 1 or 2 tablets for maintenance in most patients).

Supply: Rautrax-N — capsule-shaped tablets providing 50 mg. Raudixin, 4 mg. Naturetin and 400 mg. potassium chloride. *Rautrax-N Modified* — capsule-shaped tablets providing 50 mg. Raudixin, 2 mg. Naturetin and 400 mg. potassium chloride.

†Hutchison J. C.: Current Therap. Res. *2*:487 (Oct.) 1960.

For full information, see your Squibb Product Reference or Product Brief.

Rautrax-N*

Squibb Standardized Rauwolfia Serpentina Whole Root (Raudixin) and Bendroflumethiazide (*Naturetin) with Potassium Chloride

SQUIBB *Squibb Quality — the Priceless Ingredient*

SQUIBB DIVISION Olin

'RAUDIXIN'®, 'RAUTRAX'®, AND' NATURETIN'® ARE SQUIBB TRADEMARKS.

THE RESPONSIBILITY OF THE PHYSICIAN IN THE CERTIFICATION OF DEATH

A Review of the Rhode Island Statute with Suggested Guides from the State Department of Health

THE MEDICAL CERTIFICATION FORM in use in Rhode Island follows the international form of medical certificates recommended by the World Health Assembly. It has been accepted by all states in this country.

The most important feature of this certification form is its emphasis on the underlying cause of death as determined by the attending physician. The underlying cause of death is used in basic mortality tabulations of the state, as well as in the national and world health statistical tabulations. Thus, the physician has both responsibility and opportunity to make mortality statistics reflect the best medical opinion concerning causes of death.

For your guidance, the following highlights are points that you may wish to remember:

1) The attending physician is required by law to complete the medical section of the death certificate unless the death is one that falls within the jurisdiction of the medical examiner. To avoid any possible legal involvements, the physician should always view the body before signing the death certificate.

2) Deaths falling within the jurisdiction of the medical examiner include:

(a) any death of a person who is unattended during his last illness;

(b) any death that is, or is suspected to be, the result of an accident, homicide, suicide, or criminal abortion.

In (b) above the medical examiner must sign the death certificate even though the patient was under the care of a private physician until death.

3) In deaths from natural causes where the decedent was seen and treated for conditions which resulted in death:

(a) if the last visit was within 14 days prior to death — the attending physician is responsible for the medical certification. The medical examiner has no obligation or jurisdiction in such cases.

(b) if the last visit was between 14 and 30 days prior to death — where there is nothing about the death to suggest that it was due to anything but natural causes, the medical examiner may decline jurisdiction and refer the death certificate to the attending physician, who is then required by law to sign the medical certification.

(c) if the last visit was more than 30 days prior to death — the medical examiner should assume jurisdiction in such cases.

4) Rhode Island law places the responsibility of obtaining the full legal name of the decedent, as well as other personal data, on the funeral director. Please leave these items blank so that the funeral director can obtain the correct information in compliance with state laws.

5) Physicians should complete only the medical certification and date of death. Although the physician need not give the name of the decedent, if he wishes to add the name, it should be placed in the binding margin of the certificate by the medical certification or on the reverse side. Otherwise, the certificate will almost always have to be returned for a corrected certificate containing the full legal name.

6) It is always helpful and will expedite matters if the medical certification can be ready when the body is picked up by the funeral director (it also avoids your being bothered at your office). If this is not possible, return the signed death certificate to the funeral director promptly so that the funeral director can file it with the local registrar and obtain a permit to bury or transport the body.

7) Co-operation with the local or state registrar by replying at once to queries concerning any entries on the medical certification will avoid repetitious letters.

Method of Certification

The form of the medical certification on the Rhode Island death certificate is designed to facilitate reporting of the underlying cause of death and to obtain the necessary information on the causal and chronological sequence leading to death. It consists of two parts for entry of the causes of death with space for indicating the interval between onset and death for each condition and check boxes for indicating whether or not an autopsy was performed. (Figure 1)

Causes of death are reported in item 18. In part I

continued on page 374

CERTIFICATE OF DEATH

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF HEALTH, DIVISION OF VITAL STATISTICS
ROOM 351 STATE OFFICE BUILDING, PROVIDENCE 3, R. I.

TOWN OR CITY NUMBER STATE FILE NUMBER

This becomes a Legal Record when properly executed and will be placed in per

answers must be complete and accurate.

PLEASE TYPE. (Except Signatures) or write plainly with unfading ink

CAUSE OF DEATH Do not give mode of dying such as heart failure, asthenia, etc.

Give the disease, injury, or complication which

1. NAME OF DECEASED (Type or print) First Middle Last
2. DATE OF DEATH Month May Day 15 Year 1962
3. PLACE OF DEATH a. COUNTY
4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY
3b. CITY, TOWN OR LOCATION
3c. LENGTH OF STAY IN 3b.
4c. CITY, TOWN, OR LOCATION
3d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
4d. STREET ADDRESS
5. SEX
6. COLOR OR RACE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH
9. AGE (In years last birthday)
IF UNDER 1 YEAR Month Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME
13b FATHER'S BIRTHPLACE
14a. MOTHER'S MAIDEN NAME
14b MOTHER'S BIRTHPLACE
15. WAS DECEASED EVER IN U. S. ARMED FORCES?* (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Bronchopneumonia	3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Metastatic cancer of bladder and abdomen	1 year
DUE TO (c)	Adenocarcinoma of rectum	3 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Syphilis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from August 25, 1950 to May 15, 1962 and last saw (her) (him) alive on May 15, 1962
Death occurred at 7:45 P. m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Your signature and title
22b. ADDRESS Your address
22c. DATE SIGNED Date signed

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR ADDRESS LICENSE NUMBER
25. DATE REC'D. BY LOCAL REG.
26. REGISTRAR'S SIGNATURE

VS-2 20M 10-61

*SEE OTHER SIDE

Name of decedent if preferred

In part I, give the sequence of events that led to death, specifying last the underlying cause which initiated the train of events. Do not report symptoms or mode of dying.

In part II, report other important diseases or conditions, if any, that contributed to the death but were not related to the causes given in part I. Item 19 should be answered "Yes" or "No".

The medical examiner must sign certification and complete items 20 a-f if death was due to violence or external causes.

Items 21 and 22 are essential to the legality of the certificate and should always be completed fully.

All other items are the responsibility of the funeral director and should be left blank.

FIGURE 1

RESPONSIBILITY OF THE PHYSICIAN IN THE CERTIFICATION OF DEATH

continued from page 372

is reported the cause leading directly to death, line (a), and also the antecedent conditions, lines (b) and (c), which, in the judgment of the physician, gave rise to the cause reported in line (a), the underlying cause being stated last. The underlying cause is the disease or injury which initiated the train of morbid events leading to death. If the immediate cause of death, line (a), describes completely the sequence of events, no entry is necessary in lines (b) and (c).

To the right of the cause-of-death statements in part I of item 18, space is left for the physician to enter the approximate interval between onset of the condition and death. This should be given as accurately as possible, and the unit of time should be specified, e.g., 2 days, 4 months, 1 year. If the interval is not precisely known, an estimate may be made from the history. Entries for the time interval between onset of each condition and death are of importance in clarifying the sequence of events leading to death. Therefore, the interval between the time of diagnosis and death, which is sometimes reported, may be misleading.

In part II there should be reported any other important disease or condition that influenced the course of the illness unfavorably, and thus contributed to the fatal outcome, but which was not related to the disease or condition reported on line (a) part I as the immediate cause of death.

In all cases, item 19, on whether an autopsy was performed, should be answered "Yes" or "No."

21 and 22. Certification; physician's signature, degree or title; address; date signed. — The dates of the physician's attendance and the hour of death as well as the physician's signature and address are essential to the legality of the certificate.

Limitations of space on the death certificate and the fact that only conditions that were significant in causing death can be incorporated in mortality statistics make it necessary for the physician to be selective in giving the causes of death. He should avoid itemizing on the death certificate all conditions or diseases. Terms that describe only symptoms are undesirable.

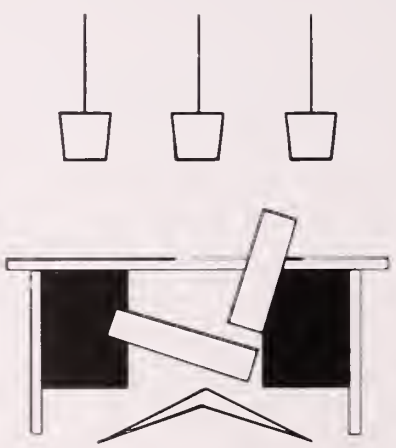
In certifying causes of death, the disease or conditions should be reported in specific terms if possible. It is recommended that the approved terms listed in the *Standard Nomenclature of Diseases and Operations** be used. It is not necessary to specify the type of organism involved in tuberculosis of the lung, but with such causes as meningitis it should be specified whether the condition was caused by a meningococcus or some other organism. When cancer is reported as a cause of death, the histological type of neoplasm and the primary site, if known, should be specified. In deaths from abortion, it should be specified whether the abortion was spontaneous or performed for therapeutic or nontherapeutic purposes.

It is recognized that it is not always possible to make a precise determination of causes of death. This is particularly true when the physician has not had the opportunity to work up the case properly. Also, there will be cases in which the relationship between the existing diseases or the sequence in which the diseases occurred is not clear. However, except in unusual circumstances, the attending physician is in a better position than any other individual to make a judgment as to which of the disease conditions led directly to death and to state the antecedent conditions, if any, which gave rise to this cause. In case of doubt, qualifying phrases may be used to reflect this uncertainty. Occasionally the knowledge of the case will be so meager that no alternative is possible except to specify "unknown."

The regulations outlining the responsibilities of the attending physician in death registration are as follows:

*American Medical Association, *Standard Nomenclature of Diseases and Operations*, edited by Richard J. Plunkett and Adaline C. Hayden, Blakiston Co., New York, 1952.

concluded on page 376

Attractive & Functional Offices
by BENÉ & CO., INC.

Designers & Suppliers of Offices
150 Dorrance Street • Providence 3, R. I. • GAspee 1-5228

If you have patients on a cholesterol depressant diet, this will be welcome news:

General Mills is now making available, through grocery stores, a Safflower Oil which is totally acceptable in the diet, and which is priced reasonably.

SAFF·O·LIFE
Safflower Oil



As you know, Safflower Oil is higher in poly-unsaturates and lower in saturated fats than any other type of readily available vegetable oil.

When an increased poly-unsaturated fatty acid intake is desirable, you can recommend Saff-o-life Safflower Oil. You can do so with the assurance that the patient will find it completely appetizing—clear, light and fresh-smelling—and priced at a level which poses no problem.

Ratio of Linoleates* to Saturates
*(Poly-Unsaturates)

SAFFLOWER OIL • 9.0 to 1.0
CORN OIL • 5.3 to 1.0
SOYBEAN OIL • 3.5 to 1.0
COTTONSEED OIL • 2.0 to 1.0
PEANUT OIL • 1.6 to 1.0

Physicians who wish recipes using Saff-o-life Safflower Oil are invited to write directly to General Mills, Inc. Address your inquiries to Professional Services Director, General Mills, Inc. Dept. 120, 9200 Wayzata Blvd., Minneapolis 26, Minnesota.

LIFE INSURANCE or DEATH INSURANCE?

SOME Medical men need DEATH Insurance ONLY.

Others need accumulating, guaranteed dollar values to meet their LIVING needs in the future — DEPRESSION — EMERGENCY — RETIREMENT, etc.

In any event, our new "CHEAPER-THAN-TERM" DEATH INSURANCE is the first step in the right direction!

Don't make any important changes in your Life Insurance or Estate plans without investigating "CHEAPER-THAN-TERM"!

For further information about this sensational new development in DEATH INSURANCE, write or phone:

ROLAND A. DEROSIER
54 Custom House Street
Providence 3, Rhode Island
TE 1-4833

TESTIMANIMAL



I get a big kick out of

WARWICK CLUB
GINGER ALE

It sings in the glass



RESPONSIBILITY OF THE PHYSICIAN IN THE CERTIFICATION OF DEATH

concluded from page 374

Section 6.2
Responsibility of the Attending Physician†

When a patient shall die, the physician in charge of the patient's care for the illness or condition shall be responsible for executing and signing the medical certification of cause of death as follows:

(a) If the physician is present at or immediately after the death, or has attended the deceased within the past 14 days, he shall execute and sign the medical certification of cause of death on the death certificate blank prescribed by the state registrar as presented to him by the funeral director.

(b) In any case where an autopsy is scheduled and the physician wishes to await its gross findings to confirm a tentative clinical finding, he shall give the funeral director notice that he attended the patient and when he expects to have the medical data necessary for the certification of cause of death. If the provisions of Section 6.1 of this regulation cannot be adhered to, he shall indicate that the cause is "pending" and sign the certification. Immediately after the medical data necessary for determining the cause of death have been made known, the physician shall, over his signature, forward the cause of death to the registrar.

(c) If the physician is unable to establish the cause of death or if a death is within the jurisdiction of the medical examiner, he shall immediately report the case to the local medical examiner and advise the funeral director of this fact. If the medical examiner does not assume jurisdiction, the physician shall sign the medical certification.

(d) An associate physician who relieves the attending physician while he is on vacation or otherwise temporarily unavailable, may certify to the cause of death in any case where he has access to the medical history of the case, provided that he views the deceased at or after death occurs and that death is from natural causes. In all other cases in which a physician is unavailable, the funeral director shall contact the medical examiner.

(e) The person in charge of an institution, as defined in Section 23-3-1 of Chapter 87, Public Laws 1961, or his designated representative, may prepare the medical certification of cause of death in cases where all pertinent aspects of the medical history are a part of the official hospital records and the death is due to natural causes. In such instances, the signature shall be that of a physician.

†From "Regulations Governing Vital Statistics," effective December 31, 1961.



Emotional control regained...a family restored... thanks to a doctor and 'Thorazine'

During the past seven years, 'Thorazine' has become the treatment of choice for moderate to severe mental and emotional disturbances because it is:

- specific enough to relieve underlying fear and apprehension
- profound enough to control hyperactivity and excitement
- flexible enough so that in severe cases dosage may be raised to two or three times the recommended starting level

Experience in over 14,000,000 Americans confirms the fact that, in most patients, the potential benefits of 'Thorazine' far outweigh its possible undesirable effects.

Of special value in mental and emotional disturbances: Tablets for initial therapy; Injection (Ampuls and Vials) for prompt control; Spansule® sustained release capsules for all-day or all-night therapy with a single oral dose.

Smith Kline & French Laboratories SK&F

Thorazine®

brand of chlorpromazine

A fundamental drug
in both office and hospital practice

For prescribing information, please see PDR or SK&F literature.

Posed by professional models.

DISTRICT MEDICAL SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

THE BI-MONTHLY MEETING of the Newport County Medical Society was held at the Hotel Viking on May 23, 1962, Donald Fletcher, M.D., presiding. The following business was conducted:

The society voted to endorse the proposal of the joint committee of the American Medical Association and the National Education Association that all schoolchildren be required to have periodic physical examinations throughout their school careers. The society also voted to request the Newport County School Superintendents to require annual physical examinations, chest X-rays and skin tests for tuberculosis for all school personnel. The proposed plan of the State Health Department to conduct tuberculosis skin tests on students in Grades I, VI and XI in all public, parochial and private schools was discussed and unanimously recommended.

The poliomyelitis immunization clinics to be held in the various towns within the county were discussed. It was voted that the public information committee chairman review and approve the advertisements to be placed in the local news media relative to these clinics.

Doctor Charles Ceppi discussed at length the Physicians Service proposal to make medical care a service feature of the Physicians Service plan as opposed to the present indemnity plan. He emphasized and urged the members to consider the great difficulties we have had with governmental regulatory agencies when an attempt has been made to change benefits. He pointed out that if an indemnity plan is adopted it will be necessary to seek the approval of the director of business regulation before any future changes can be made in fee schedules. Doctor Ceppi also discussed the American Medical Association's proposal for service benefits for the aged. Doctor Frank Logler discussed the possible impact of the King-Anderson bill on current medical practice. He pointed out that currently it is a function of the hospital administrator to determine which patients go on house service and it might well be advisable to change the mechanism by which patients are accepted or rejected for house service care if the King-Anderson bill should become law.

The King-Anderson bill was discussed at great length and it was pointed out that patients eligible for social security would be entitled to out-patient diagnostic services after a $20.00 deductible had been paid to the hospital and that such services would include the care rendered by any physician employed by the hospital. The impact of such a change on the private practice of medicine was discussed. It was also pointed out that although President Kennedy has stated there is a free choice of physicians, one cannot make use of this important provision of the bill, i.e., out-patient service, if he wishes to have his own physician but must rather accept the physician employed by the hospital. Patients thus wishing to choose their own physician would be subject to an economic penalty.

Doctor Charles Serbst discussed communications that he had with U.S. Senators Pell and Pastore and U.S. Congressmen Fogarty and St. Germain relative to a meeting with us to discuss the health problems of the state and particularly the King-Anderson bill as it would affect local medical practice. Doctor Serbst reported that all four of our congressional representatives had refused to meet with us and that, furthermore, Senator Pell had informed him that any such meeting would be entirely unproductive since he was already committed to the principle of social security medical care for the aged.

It was unanimously voted that the society send a letter of congratulations to Captain Joseph Yon, M.D., USN, the current commanding officer of the U.S. Naval Hospital at Newport congratulating him on his election as an honorary member of the Rhode Island Medical Society and welcoming him to the Newport County Medical Society meetings and activities. The application of Elias Ramsis, M.D., was reviewed and he was unanimously accepted as a member of the Newport County Medical Society. The application for membership by Robert Frazier, M.D., was referred to the censors.

Submitted by,

RICHARD R. KNOWLES, M.D., *Secretary*

WASHINGTON COUNTY MEDICAL SOCIETY

The quarterly meeting of the Washington County Medical Society was held in the Staff Room of the Westerly Hospital on April 11, 1962.

The meeting was called to order at 11:30 A.M., by Doctor P. J. Celestino at the request of Doctor J. L. C. Ruisi, the president.

The minutes of the previous meeting were unanimously accepted as read.

Unfinished Business: Re: the Public Information Committee. Doctor J. McGrath attended this meeting and volunteered to comment. Most of the members possessed information concerning the urgent problems of medical legislation. Doctor McGrath urged that each Society meet with the legislators of the state and give proper information on important questions. The meeting had been held at the Haversham Inn. Doctor Morrone was impressed that there was no desire to change the Blue Cross at this meeting, which was held in February.

Communications: A letter from the Rhode Island Medical Society dated February 14, 1962 regarding poliomyelitis immunization, and the need to have the impetus come from the medical profession through the local societies, was noted.

A letter from Doctor L. C. Ruisi dated February 20, 1962 stated that this matter would be brought up at this current meeting.

Disaster and Civil Defense Planning. As a result of a meeting held February 15, 1962 it was requested that three doctors be named to such a committee. The following are on this committee: Doctors L. LaPere, Kendall, and McGrath.

An application from Doctor Robert L. Lombardo for membership to the Washington County Medical Society was read; action on this application to be decided before the end of this meeting.

Action: Doctor Lombardo's application accepted, moved by Doctor S. Nathans.

An inquiry from Miss Mary F. Gardiner concerning medical assistance and clerical work was placed on file with the secretary, further inquiries of interested parties to be directed to the secretary.

New Business: Doctor Ruisi commented on the proposed action of the Society concerning the establishment of polio clinics for administration of vaccine. Doctor L. A. Morrone did not see the necessity of polio clinics in view of the fact that the program has been going on for eight years. Additional discussion ensued regarding various aspects of this problem ranging from (a) entering wedge tending toward socialized medicine; (b) public relations; (c) question of real need for clinics; (d) the fact that many recipients of clinic vaccine were well able to afford to go to their own private physician.

Doctor S. Nathans moved that the polio vaccine be administered in the doctor's office; that the Society agrees in principle with the health department; that the state supply of vaccine be used and the fee recommended by the health department be

concluded on next page

AIR AMBULANCE SERVICE

To any part of the country — day or night. Multi-engine equipment, air line rated pilots. Fully equipped amblance, stimulant tray, oxygen therapy etc. Registered nurse on all trips. We can transport stretcher cases in and out of the smallest airports.

No increase in rates over ground transportation

CUSHMAN'S

AIR AMBULANCE SERVICE

47 NISBET ST., PROVIDENCE, RHODE ISLAND

Call DE 1-4840



Health Havens

100 WAMPANOAG TRAIL
EAST PROVIDENCE, R. I.
438-4275

A Truly Modern, Intermediate Care Facility Providing the Ultimate in Nursing Home Care at Reasonable Rates

Prepared to accept and adequately care for many acute cases as well as the more general convalescent and nursing home patients. We are limited to adults.

Our Nursing Administrator, Mary E. Baxter, R.N., will be pleased to discuss patient care with you.

followed; and that the injections be given free if patient is unable to afford a fee. The motion was seconded by Doctor L. C. Cerrito. The motion was passed unanimously by the Society.

The House of Delegates held a special meeting on February 21, 1962 regarding a Medical Political Action Committee to be organized by the state Medical Society, and the introduction of a motion for the Society to retain legal counsel, and a lobbyist, whose task would be to inform the Society of bills affecting them, to present the Society's view on the issues, and to influence the legislators in the Society's behalf. Comments by Doctor Nathans regarding the real needs of assistance for Doctor John E. Farrell regarding the above matters, additional comments regarding Doctor Farrell's abilities was made by Doctor James McGrath. Complexities of the present controversial legislation are evident.

In reference to the above House of Delegates meeting, Doctor Morrone moved that we recommend an increase in the executive staff to assist the executive secretary in his many duties presented by the various legislative problems confronting medicine today. This motion was seconded by Doctor Cerrito. So voted.

Doctor Ruisi read the entire report of *The Blue Ribbon Commission* to the Society. This refers to S-11, Governor Notte's proposal for a Blue Ribbon Commission to "assure the most comprehensive medical coverage for all Rhode Island." Only allusion can be made in this report to the above.

A note from the Rhode Island Medical Society concerning the organization of Civil Defense and Disaster Planning was commented upon by Doctor J. McGrath and Doctor Louis LaPere. A committee representing this Society is as follows: Doctor LaPere, Doctor Kendall, and Doctor J. McGrath.

The object of this committee is to train as many citizens as possible in a "Medical Self-Help Training Program" to be initiated by the state and county societies, this training to be a self-perpetuating group, initially started by physicians. Doctor LaPere pointed out that members of the Ambulance Corps, Fire Department, Rescue Squads, and Police would be trained.

An interesting discussion was given by Mr. Donald K. Trescott, estate analysis officer of the Industrial National Bank, Providence, about the Mutual Fund Program endorsed by the Rhode Island Medical Society. Mr. Trescott was accompanied by Mr. Albert Solinder, manager of the Westerly Branch of the Industrial National Bank.

Details were presented concerning the flexibility, comparison, and advantages of this type of investment of special interest to professional people. A question period followed.

This meeting of the Society was attended by the following members: Doctors P. J. Celestino, L. C. Cerrito, D. Chimento, D. C. Dewees, F. Eckel, H. B. Grainger, C. S. Hathaway, S. F. Johnston, L. LaPere, A. L. Manganaro, J. A. McGrath, J. Martin, J. MacIver, L. A. Morrone, J. J. O'Brien, M. Robinson, J. L. C. Ruisi, R. Singer, Z. T. Tang, J. R. Tatum, W. H. Tully, Jr., J. J. Walsh, F. M. Palaia, and R. L. Lombardo.

The meeting adjourned at 1:20 P.M.

Respectfully submitted,
MARTIN J. O'BRIEN, M.D., *Secretary*

The physician or surgeon is not in competion with his fellow practitioner at all, but is in competition with the average standard of the medical qualification of his time. This standard is the line dividing mediocrity and incompetency of varying degrees from knowledge and efficiency. He who keeps above the standard desires companionship. Therefore, if we elevate the ethical and educational average, we increase the brotherhood of the profession and enhance the percentage of efficiency to the public. *The effect of capital and labor organization has been to lessen individual exertion and reduce men to a common or mediocre level — their decadence is inevitable.* The ideal of medicine, on the contrary, must be the stimulation of individual exertion to the highest degree and the establishment of a standard, the attainment of which should be the one great desire of every member of our profession, each to assist the other in his upward progress.

Advancement is retarded by the failure of the individual to utilize and avail himself of opportunity. We are all spendthrifts of time; all overlook great opportunities. Many are ruminants on their imaginary disadvantages in the contest: these never become producers. The demand of the times is that we level every opposition and make smooth the way for general progress, enlightenment, education, and the higher ethical obligations. The individual is responsible for his own position and to a limited but positive degree for that of his fellow practitioner. When given a diploma from a medical school or a license to practice, we are all supposed to be equal. But no insignia makes men equal in medicine more than in any other line of endeavor. By their own superior intellectual qualifications, their fidelity to purpose, and above all their indefatigable labor the few become leaders.

. . . Extract from Doctor John B. Murphy's presidential address to the American Medical Association, June, 1911.



a relaxed mind in a relaxed body

with

Trancopal®

Brand of chlormezanone

effective TRANQUILIZER ■ potent MUSCLE RELAXANT

When you prescribe Trancopal you can see how this "tranquilaxant" speedily helps the anxious patient. It quiets his psyche — and this quieting helps relax tense muscles. It eases muscle spasm — and this easing helps put the mind at rest.

DeNyse[1] notes that the effect of Trancopal as a quieting agent ". . . may play a part in the skeletal muscle relaxing results obtained." Gruenberg[2] used Trancopal to treat patients with musculoskeletal disorders, and commented: "In addition to relieving spasm and pain, with subsequent improvement in movement and function, Trancopal reduced restlessness and irritability in a number of patients."

Trancopal has an unsurpassed record of safety. Very few side effects occur with Trancopal. You may see them in only about two out of a hundred patients, and they will almost always be mild.

Available: 200 mg. Caplets® (green colored, scored), bottles of 100
100 mg. Caplets (peach colored, scored), bottles of 100

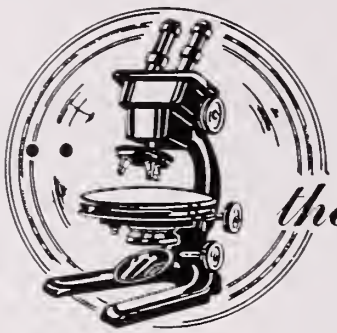
Dosage: Adults, 1 Caplet (200 mg.) three or four times daily;
children (5 to 12 years), from 50 to 100 mg. three or four times daily.

Before prescribing, consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

References: 1. DeNyse, D. L.: M. Times 87:1512 (Nov.) 1959.
2. Gruenberg, F.: Current Therap. Res. 2:1 (Jan.) 1960.

Winthrop LABORATORIES New York 18, N.Y.

1649M

THROUGH . . .  *the Microscope*

Of Hogs and Humans

In medicine, a bad treatment is almost certain to follow a mistaken diagnosis. Unrealistic, harmful laws are likewise apt to follow inaccurate statements about the conditions which these laws are supposed to correct, the director of public relations of Smith, Kline and French Laboratories pointed out recently.

This may well happen with pending legislation to control the prescription drug industry. It is a complicated, technical industry and even highly placed government spokesmen get the facts about it twisted a bit.

Not long ago, Secretary of Health, Education, and Welfare Ribicoff remarked that men, women and children should receive the same protection against the marketing of worthless drugs as do hogs, sheep and cattle. This made headlines in many papers, was repeated in a Presidential message to Congress, and undoubtedly created a strong public impression. The consumer could easily conclude that animals are protected by law against bad drugs and that human beings are not. But the facts are otherwise.

Medicines for animals and human beings alike are regulated by two sets of laws, one covering biological products such as serums and vaccines, the other covering nonbiological medications usually dispensed in the form of tablets or capsules.

It is true that for animals the Virus, Serum, Toxin and Analogous Products Act of 1913 prohibits the sale of "worthless" products, and that the specific word "worthless" is not used in the corresponding legislation relating to medicines for man. It is equally true, however, that the Act relating to human biologicals, the Virus, Serum, and Toxin Act of 1944, affords human beings every bit as strong protection. In this Act, the Public Health Service is given authority to insure "the continued safety, purity and potency of biological medicines." Moreover, the product must "effect a given result." It cannot, in other words, be worthless.

With respect to other medicines, both animals and humans are protected by *exactly the same law* — the Food, Drug, and Cosmetic Act of 1938.

Obviously, then, hogs do not receive greater protection than humans. This is the fact of the matter, and when the fact pertains to such a vital question as the public health, it is important to keep the record straight.

Wages Account for Bulk of Hospital Costs

The sharp rise in hospital costs over recent years is due largely to higher wages and the scientific breakthrough in medicine. Neither surgeons' fees nor "hotel"-type services such as television sets, telephones and choice of entrée at mealtime have contributed substantially to the increase, says the Health Insurance Institute.

Citing statistics of the American Hospital Association, the Institute said higher payrolls represented nearly two thirds of the increase in costs in U.S. general hospitals since 1956.

Between 1956 and 1960, average hospital costs per patient day increased by $8.08, from $24.15 to $32.23. Labor costs accounted for 65 per cent of the rise, representing $20.08 of the total average cost in 1960 as against only $14.85 in 1956.

Advances in scientific medicine have resulted in a rising investment in hospital equipment and treatment facilities. Equipment like cobalt, kidney and heart lung machines, along with improved facilities, raised the value of ownings of the nation's nongovernmental hospitals by 44 per cent over the 1956-60 span. Assets climbed from $7.5 billion to $10.9 billion.

By comparison, surgeons' fees, as measured by the consumer price index, were up only 11 per cent.

A study of 54 general hospitals in the New York area showed that "hotel"-type services, which had accounted for half of the average per diem costs in hospitals in 1947-49, dropped to 28 per cent in 1960. Hospital services, including such items as medical and surgical supplies, pharmacy, operating rooms and physical therapy, now account for the largest segment of the hospital dollar.

Physician Population Boosted by 4,500

The physician population of the United States and its possessions increased by about 4,500 in 1961, the American Medical Association has reported.

Medical licensure statistics for 1961, compiled by the A.M.A.'s Council on Medical Education and Hospitals, were published in the June 9 A.M.A. Journal.

A total of 8,023 first licenses to practice medicine and surgery were issued in 1961, the report showed. Since approximately 3,500 physicians died during the year, the physician population increased by about 4,500, compared with a net gain of about 4,330 in 1960.

Of 8,714 applicants for licensure by written examination, 7,650 passed while 1,064 (12.2 per cent) failed, the report showed. However, the rate of failure in approved medical schools was 2.8 per cent. Twenty-six approved schools had no failures among their graduates.

The greatest number of graduates from any one school to be examined was 214 from the University of Tennessee College of Medicine, the report said.

Statistics also were reported on the Educational Council for Foreign Medical Graduates, founded in 1957 to certify that foreign-trained physicians entering the United States had an education equivalent to that of graduates of approved medical schools in this country.

The Council, which has held eight qualification examinations for foreign medical graduates, said the "net effect" of the ECFMG certification plan has been not to restrict but rather to increase both the number and the quality of foreign medical graduates coming to the United States for graduate training in hospitals.

In 1961, more than 3,600 foreign medical graduates were qualified directly from abroad by the ECFMG, the council said. The number of foreign medical graduates taking the ECFMG examination abroad is now greater than the number taking it in the United States, the council said.

Health Benefits Up in All 50 States

Each of the nation's 50 states showed an increase during 1961 in the amount of health insurance benefits received from insurance companies, the Health Insurance Institute reported recently in its annual estimate of state benefit payments.

The increases ranged from a high of 29.0 per cent in the states of Alaska and New Mexico down to 0.8 per cent in West Virginia, the Institute said.

Although the residents of Alaska and New Mexico recorded the greatest percentage increase in benefit payments from insurance companies last year, California led all other states in terms of benefit dollars received — some $425 million. New York followed with more than $369 million, said the Institute.

Regional Breakdown

On a regional basis, the Northeast and the South each showed an increase of 11.5 per cent, followed by the Midwest with 9.7 per cent and the West with 9.4 per cent.

The nine Northeast states of Connecticut, Massachusetts, Maine, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont showed an 11.5 per cent boost with an increase in benefits received from $772 million to more than $861 million.

Rhode Islanders received $6,263,000 in 1961, as against $5,665,000 the previous year, resulting in a 10.6 per cent increase.

FDA Launches Campaign Against Fake Diagnostic Machine

A nation-wide seizure campaign to stop the use of a fake diagnostic machine found in offices of hundreds of health practitioners was announced recently by the Food and Drug Administration.

The announcement follows a refusal by the United States Supreme Court June 11 to review actions of lower courts banning the device from interstate shipment.

FDA Commissioner George P. Larrick called the machine "a peril to public health because it cannot correctly diagnose any disease." He said "thousands of patients are being hoodwinked by its use into believing they have diseases which they do not have, or failing to get proper treatment for diseases they do have."

The machine, known as the Micro-Dynameter, is supposed to be effective for detecting scores of serious diseases by measuring electric currents generated by metal plates applied to areas of the body. FDA scientists proved that the only condition measured by the device is the amount of perspiration on the skin of the patient.

concluded on next page

Curran & Burton, Inc.

INDUSTRIAL
AND WHOLESALE

COAL **OIL**

17 CUSTOM HOUSE STREET
PROVIDENCE, R. I.
DExter 1-3315

Training Program in Management of Emotional Problems of Children

Boston University School of Medicine, Department of Psychiatry, in co-operation with Boston City Hospital, Department of Pediatrics, announces a July registration for the second of its training programs in the recognition, understanding, and management of emotional problems of children. This is a part-time course, to start in September, 1962, designed for practicing pediatricians and other interested physicians.

Each week the physician will be expected to attend one two-hour session during which time he will have the opportunity to interview and examine clinic pediatric patients and their parents. At this session, the physician will discuss his interviews individually with a training supervisor. In addition to the individual supervision, a seminar in emotional development of children will be available.

The major goals of the training program are to help the physician implement his pediatric techniques by means of increased psychiatric understanding and to improve his ability to recognize, understand, and handle emotional problems as they naturally arise in his practice. Special emphasis will be given to:

1) developing techniques for handling the overly-anxious, overly casual, or otherwise "difficult" parent and enlisting the parent's support in effective pediatric care.
2) improving history-taking and interviewing techniques so as to facilitate the understanding of children and parent-child relationships.
3) exploring effective ways of preparing children for diagnostic and surgical procedures by learning more about what such procedures mean to children and to their parents.
4) enlarging the ability of the physician to identify early signs of parent-child conflicts so that he may either give appropriate help or determine whether a psychiatric referral is necessary.
5) gaining new ways of understanding and dealing with patients with psychosomatic illnesses and with problems such as those that arise in the areas of feeding, elimination, sleep, and school.

The course will be adapted wherever possible to meet the individual needs of the participating physician.

For further information write to: Box 1, Boston University School of Medicine, Department of Psychiatry, 80 East Concord Street, Boston 18, Massachusetts.

IN THE EDITOR'S MAILBOX

May 3, 1962

My dear Dr. Goldowsky:

I do want to thank you for the editorial in the March issue of the RHODE ISLAND MEDICAL JOURNAL, *Air Pollution — Public and Private.*

I have long been aware of the serious discourtesy shown to patients in our hospitals by doctors, nurses, and personnel, where smoking has been allowed.

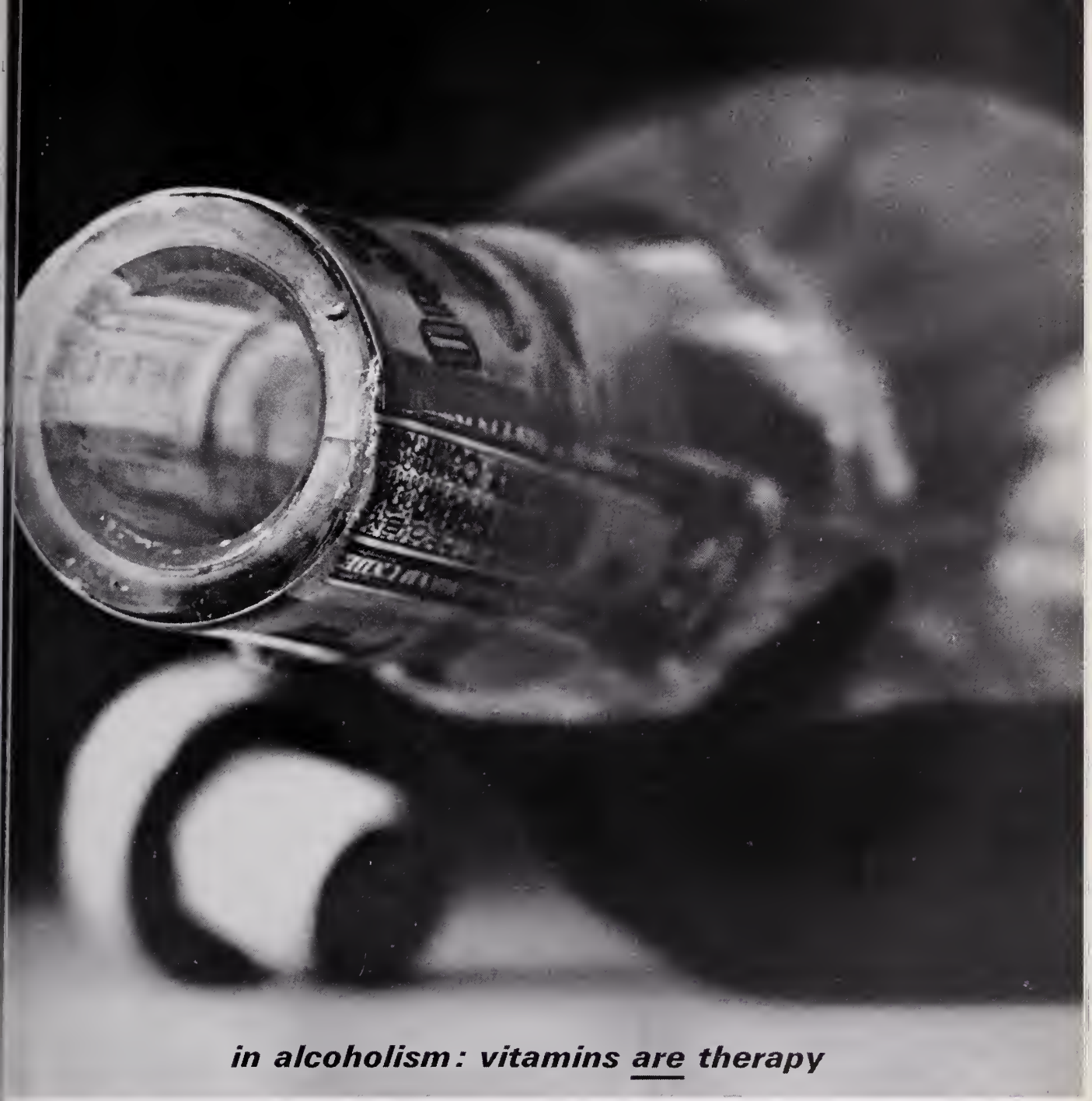
The fire hazard has always seemed to be very great. Now that we know so clearly about the health hazard we can hope for better things.

I am grateful to you for the editorial.

Sincerely yours,
SARAH N. HALLETT
Providence, R. I.

INDEX OF ADVERTISERS

	PAGE
Ames Company, Inc.	336
E. P. Anthony, Inc.	365
Armour Pharmaceutical Company	346
Bené & Company	374
J. E. Brennan & Co.	365
Burroughs Wellcome & Co.	339, 343
Cushman's Air Ambulance Service	379
Curran & Burton, Inc.	383
Derosier Agency	376
Duffy Mott Company	345
Endo Laboratories	341
Fuller Memorial Sanitarium	340
General Mills, Inc.	375
Health Havens	379
Industrial National Bank	Back Cover
Lederle Laboratories	3d Cover
Eli Lilly & Co.	Front Cover
Medical Bureau	362
Medical Milk Commission	342
A. B. Munroe Dairy	370
Parke, Davis & Co.	2d Cover and 333
Physicians Service	334
G. D. Searle Co.	348
Smith, Kline & French Laboratories	377
Social Security Meeting Announcement	Insert between pages 364-365
E. R. Squibb Co.	337, 371
Warwick Club Beverages	376
Winthrop Laboratories	381



in alcoholism: vitamins are therapy

A full "comeback" for the alcoholic is partly dependent on nutritional balance...aided by therapeutic allowances of B and C vitamins. Typically, the alcoholic patient is seriously undernourished...from long-standing dietary inadequacy, from depletion of basic reserves of water-soluble vitamins. Supplied in decorative "reminder" jars of 30 and 100.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y. Lederle

STRESSCAPS®

Stress Formula Vitamins Lederle



To help you and your family build systematically and surely for the future

A new type of trust service from Industrial National Bank

THE BUDGET TRUST

NOW INDUSTRIAL NATIONAL offers you a personal budget plan to help you build for the future — a budget plan you can start on right now! It's a new type of trust service — *The Budget Trust.*

How your Budget Trust works

You start your Budget Trust with $100 or more. Then you make regular planned deposits. It may be as little as $25 a month.

Your funds are invested in common stocks selected primarily with an eye to long-term growth rather than current income. Your lawyer draws the Trust Agreement — and Industrial National acts as your trustee. All income earned is added to your Budget Trust and reinvested. The continuous inflow of funds gives you the maximum advantage of dollar-cost-averaging.

Flexibility of your Budget Trust

Your Budget Trust is revocable at any time, in part or in whole. You may withdraw any part of your funds on quarterly withdrawal and entry dates.

You will discover, though, that a Budget Trust — with its systematic deposit feature — will make it much easier for you to accumulate the funds you need for your long-range goals. It's something important to consider when you think ahead to your retirement, your children's education, or any other years-from-now project.

Your Budget Trust brings you the benefits of Industrial National's broad investment and trust experience. One of our trust officers will be glad to discuss the new Budget Trust with you. To learn more about the Budget Trust, visit any Industrial National office, or call Mr. Allingham at JA 1-9700.

INDUSTRIAL
NATIONAL BANK OF
RHODE ISLAND

45 Neighborhood Offices Serving Rhode Island

Member Federal Reserve System
Member Federal Deposit Insurance Corporation

RHODE ISLAND

Medical Journal

AUGUST, 1962

Volume XLV, No. 8

Table of Contents, page 387

LIBRARY
SEP 18 1962
OF MEDICI



. . . even though surrounded by allergens. Co-Pyronil® provides smooth, continuous control of allergic symptoms—relief in minutes for hours, with virtually no side-effects. And there is a dosage form for every allergic patient.

Pulvules®
Suspension
Pediatric Pulvules

Co-Pyronil®
(pyrrobutamine compound, Lilly)

Each Pulvule contains Pyronil® (pyrrobutamine, Lilly), 15 mg.; Histadyl® (methapyrilene hydrochloride, Lilly), 25 mg.; and Clopane® Hydrochloride (cyclopentamine hydrochloride, Lilly), 12.5 mg. Each pediatric Pulvule or 5-cc. teaspoonful of the suspension contains half of the above quantities. This is a reminder advertisement. For adequate information for use, please consult manufacturer's literature. Eli Lilly and Company, Indianapolis 6, Indiana.

258015

Lilly


R IS FOR RAGWEED...
MOST TROUBLESOME ALLERGEN
R

WHEN DISCOMFORTS MOUNT WITH THE POLLEN COUNT

BENADRYL®

antihistaminic-antispasmodic

RELIEVES SYMPTOMS OF HAY FEVER

BENADRYL provides effective dual action to help control the allergic attack.

Antihistaminic action: A potent antihistaminic, BENADRYL breaks the cycle of allergic response, bringing relief of nasal congestion, sneezing, lacrimation, and pruritus.

Antispasmodic action: Because of its inherent atropine-like properties, BENADRYL affords relief of bronchial spasm.

BENADRYL Hydrochloride (diphenhydramine hydrochloride, Parke-Davis) is available in a variety of forms including: Kapseals,® 50 mg.; Capsules, 25 mg.; Emplets® (enteric-coated tablets), 50 mg.; in aqueous solutions: 1-cc. Ampoules, 50 mg. per cc.; 10- and 30-cc. Steri-Vials,® 10 mg. per cc.; Elixir, 10 mg. per 4 cc.; Cream, 2%; and Kapseals of 50 mg. BENADRYL Hydrochloride with 25 mg. ephedrine sulfate.

This advertisement is not intended to provide complete information for use. Please refer to the package enclosure, medical brochure, or write for detailed information on indications, dosage, and precautions. 93162

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit 32, Michigan

BRIEFS

FROM THE PHYSICIANS SERVICE PLAN OF THE RHODE ISLAND MEDICAL SOCIETY

How often does a patient ask...

Which Surgical-Medical Plan Delivers the Most Value?

New Cost Analysis Gives the Facts!

The arithmetic of this survey is simple. It shows that your Physicians Service Plan pays the highest level of benefits for every subscriber's dollar because its cost of operation is abont *one half* the national average for Blue Shield Plans. Here are the facts:

RHODE ISLAND	NATIONAL
18c	**35c**
cost per contract per month	*composite average cost per contract per month*

These figures are taken from the "Functional Cost Report", the initial report of a national comparative cost analysis recently released by the Association of Blue Shield Plans.

This study shows that your Physicians Service has the lowest cost per contract per month of any of the 48 Blue Shield Plans participating in the program. It is additional evidence. based upon uniform cost accounting systems, of the low dollar cost, as well as low percentage cost of operating Physicians Service.

This record of efficiency means more money is returned in health care benefits . . . more returned to the physician, the patient, and the commnnity.

31 CANAL ST., PROVIDENCE 1, RHODE ISLAND • PHONE: TEMPLE 1-7300

The RHODE ISLAND MEDICAL JOURNAL

Editorial and Business Office: 106 Francis Street, Providence, R. I.

Editor-in-Chief: SEEBERT J. GOLDOWSKY, M.D.

Managing Editor: JOHN E. FARRELL, SC.D.

Senior Editors

ALEX M. BURGESS, SR., M.D. HENRI E. GAUTHIER, M.D.

Advisory Board

(in addition to editors listed above)

JOHN A. DILLON, M.D. JOHN F. W. GILMAN, M.D. ROBERT V. LEWIS, M.D.
PETER L. MATHIEU, M.D. JOSÉ M. RAMOS, M.D. ROBERT W. RIEMER, M.D.
JACK SAVRAN, M.D. LESTER L. VARGAS, M.D.

Owned and Published Monthly by
THE RHODE ISLAND MEDICAL SOCIETY
Second-class postage paid at Providence, Rhode Island
Copyright, 1962, the Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island
Single copies, 25 cents . . . Subscription, $2.00 per year.

Volume XLV, No. 8 August, 1962

TABLE OF CONTENTS

PAGE

CONGENITAL MUSCULAR TORTICOLLIS, Hematoma, Fact or Myth, The 5th Murray S. Danforth Oration, *George J. Garceau,* M.D. 401

PREVENTION — A CHALLENGE TO THE MEDICAL PROFESSION, *Aaron W. Christensen,* M.D. 405

DOCTORS, INCORPORATED, *Charles P. Williamson* 409

PROPOSED STATUTE FOR PROFESSIONAL CORPORATIONS 412

EDITORIALS

A Backward Step? 415

Doctors, Incorporated 415

Medical Aspects of Sports 416

Phokomelia and Drug Regulation 416

DEPARTMENTS

Fiske Fund Prize Essay, 1962, Announcement 388

Appointed Committees, 1962, The Rhode Island Medical Society 392

The Washington Scene 396

Gross Unprofessional Conduct, Rhode Island Statute 417

Woman's Auxiliary, Annual Reports, 1961-62 418

Through the Microscope 432

Family Day, Auxiliary and Society, Announcement 434

Fiske Fund Prize Dissertation

1962

The Trustees of the Fiske Fund of The Rhode Island Medical Society announce the following subjects for the Prize Dissertation of 1962:

"Etiological Factors in the Development of Congenital Anomalies"

* * *

"Progress in the Relief of Hearing Defects"

For the best dissertation on either subject worthy of a premium they offer the sum of five hundred dollars ($500.00). The dissertation will be particularly graded on the basis of original work by the author. Each competitor for the premium is expected to conform with the following regulations:

To forward to the secretary of the Trustees on or before the eleventh day of December, 1962, free of all expense, a copy of his dissertation with a motto thereon, and also accompanying it a sealed envelope bearing the same motto, inscribed on the outside, with his name and address within.

Previously to receiving the premium awarded, the author of the successful dissertation must transfer to the Trustees all his right, title and interest in and to the same, for the use, benefit, and advantage of the Fiske Fund.

Dissertations, other than the successful one, will be returned to the authors.

The dissertations must be typewritten, double spaced on standard typewriter paper, and should not exceed 10,000 words.

SECRETARY to the TRUSTEES
John E. Farrell, Sc.D.
106 Francis Street
Providence 3, Rhode Island

ARTHUR E. HARDY, M.D.
ROBERT R. BALDRIDGE, M.D.
THOMAS PERRY, JR., M.D.
TRUSTEES



A new answer to one of America's leading health problems

60 DELICIOUS FOODS THAT MAKE WEIGHT CONTROL EASIER!

Here is a practical and down-to-earth method to help overcome obesity, the nation's No. 1 diet problem—and prime stealer of doctor's consultation time. Now a new group of 60 delicious Mott's Figure Control Food products uses the best of nutrition knowledge to create quality dishes, lower in calories by an average of 50%. Indicated calorie savings can be made pleasantly and accurately while eating normal-size portions by using these calorie-controlled foods in place of higher calorie dishes. Protein, vitamin and mineral food values are retained.

Low carbohydrate, low fat: Fats are largely extracted from meats and poultry in a way that cannot be done at home. Sauces and dressings are prepared with a high proportion of non-fat milk solids, vegetable colloids, all are delectably "natural" and tempting in flavor. Fruits, juices, desserts and sauces are prepared where indicated with non-caloric sweeteners—natural fruit values are intact, extra sugars reduced. The carbohydrate, protein and fat content appears on all labels along with the calorie count. Useful for diabetic diets, too.

Easy medical tool for doctors: Less need for drugs, no possible dangerous side effects, not even temporary dislocation of meal patterns. Figure Control Foods include: Soups, Meats & Poultry, Popular Sauces, Salad Dressings, Preserves, Syrup, Fruits, Drinks, Desserts and Sweeteners.

New Mott's Figure Control® Foods offer Good Eating at Half the Usual Calories

	Quantity	Figure Control Calories	"Regular" Food Calories
Apple-Grape Drink	½ cup	20	52
Five-Fruit Juice Breakfast Drink	½ cup	20	52
Braised Beef and Vegetables	6½ oz.	184	380
Meat Balls in Brown Gravy	3½ oz.	84	280
Chopped Chicken Livers	1 oz.	31	100
Chicken a la King	3 oz.	72	230
French Style Dressing	1 tbsp.	10½	60
Brown Gravy	1 tbsp.	7	21

	Quantity	Figure Control Calories	"Regular" Food Calories
Applesauce	½ cup	48	90
Fruit Cocktail	½ cup	44	90
Cherry Pie Filling	1 oz.	20	60
Chocolate Topping	1 tbsp.	8	63
Preserves (Peach, Strawberry)	1 tbsp.	9	55
"Maplette" Syrup	1 tbsp.	9	55
Liquid or Powder Sweetener	(to equal 1 tbsp. of sugar)	0	16



Complete menus, recipes, calorie chart available for professional distribution, with weight control guides you can distribute with confidence: all menus meet N.R.C. Recommended Daily Allowances. **Use this handy order form:**

FIGURE CONTROL FOODS
Duffy-Mott Company
370 Lexington Avenue
New York 17, New York

Please send____free copies of YOUR WEIGHT CONTROL PLAN for use with patients.

Dr._____

Address:_____

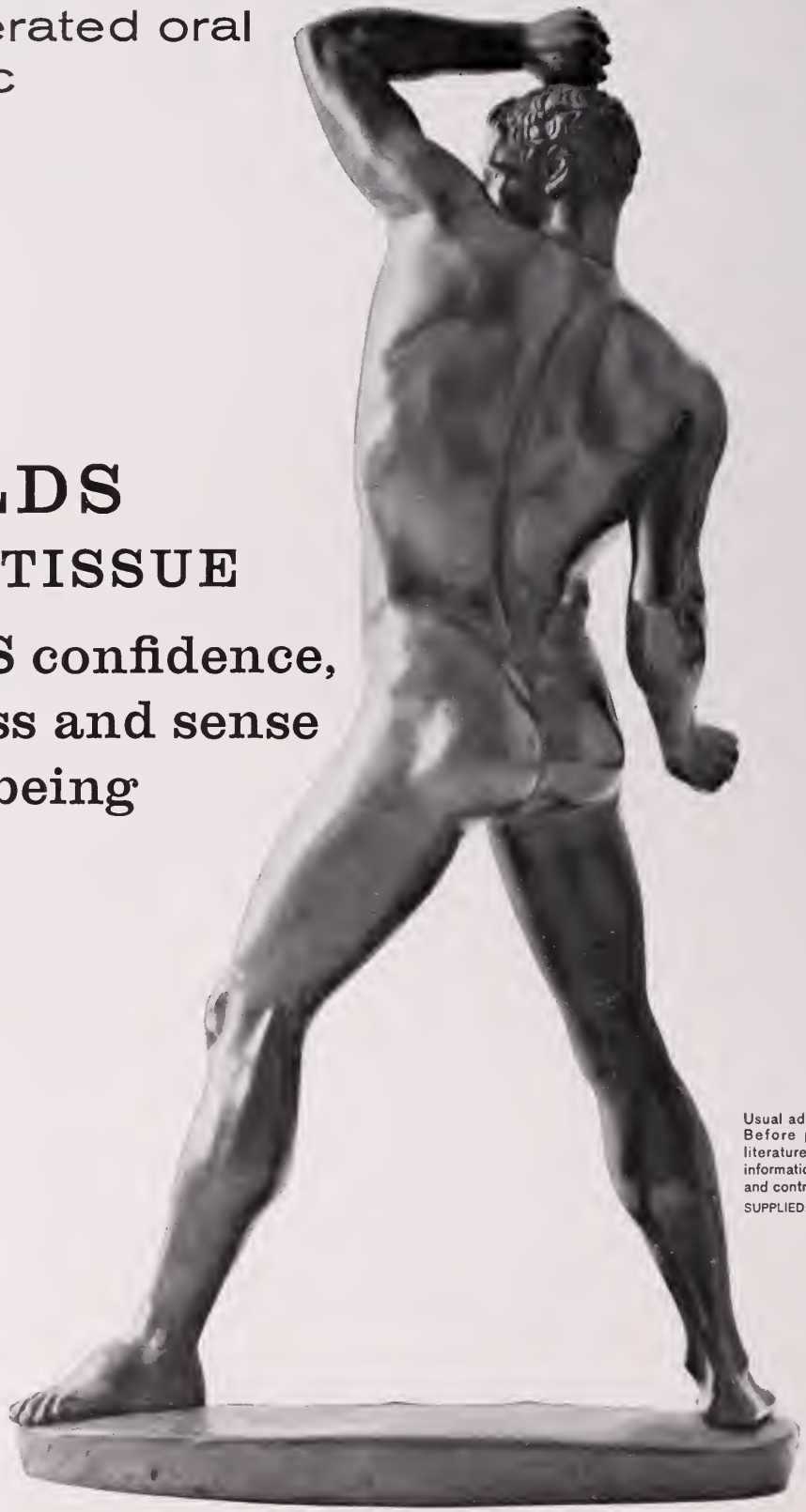
City:_____ Zone:____ State:_____

THE SIGNIFICANT NEW PHYSIOTONIC

WINSTROL®

BRAND OF STANOZOLOL

well tolerated oral anabolic



BUILDS
BODY TISSUE

BUILDS confidence, alertness and sense of well-being

Usual adult dose: 1 tablet t.i.d. Before prescribing, consult literature for additional dosage information, possible side effects and contraindications.

SUPPLIED: 2 mg. tablets. Bottles of 100.

Winthrop
LABORATORIES
New York 18, N.Y.

With WINSTROL, patients look better...feel stronger—because they are stronger



in fractures: vitamins are therapy

Few factors are more fundamental to tissue and bone healing than nutrition. Therapeutic allowances of B and C vitamins are important for rapid replenishment of vitamin reserves which may be depleted by the stress of fractures. Metabolic support with STRESSCAPS is a useful adjunct to an uneventful recovery. Supplied in decorative "reminder" jars of 30 and 100.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.

STRESSCAPS®

Stress Formula Vitamins Lederle

APPOINTED COMMITTEES . . . 1962-1963

THE RHODE ISLAND MEDICAL SOCIETY

Advisory Committee to R. I. Chapter American Physical Therapy Association

John H. Gordon, M.D., *Chairman*
Eric Denhoff, M.D.
Louis Sage, M.D.

Committee on Aging

Richard Kraemer, M.D., *Chairman*
Edward Asprinio, M.D.
Alex Burgess, Sr., M.D.
Charles D. Charon, M.D.
Robert W. Drew, M.D.
Janis Gailitis, M.D.
John F. W. Gilman, M.D.
Joseph McWilliams, M.D.
Rudy K. Meiselman, M.D.
Ezra Sharp, M.D.
Mark A. Yessian, M.D.

Blood Bank Committee

Enold H. Dahlquist, M.D., *Chairman*
George W. Anderson, M.D.
Jacob Dyckman, M.D.
Leroy W. Falkinburg, M.D.
Herbert Fanger, M.D.
Erwin O. Hirsch, M.D.
Stephen J. Hoye, M.D.
John M. Malone, M.D.
William A. McDonnell, M.D.
Gary Paparo, M.D.
Henry J. Tweddell, M.D.

Cancer Committee

George V. Coleman, M.D., *Chairman*
Emanuel W. Benjamin, M.D.
Edmund Billings, M.D.
Henry C. McDuff, Jr., M.D.
Herbert Fanger, M.D.
J. Merrill Gibson, Jr., M.D.
Stephen J. Hoye, M.D.
Simon G. Lenzner, M.D.
Thomas Murphy, M.D.
George W. Waterman, M.D.

Child-School Health Committee

Rudolph A. Jaworski, M.D., *Chairman*
Lewis Abramson, M.D.
John T. Barrett, M.D.
Briand Beaudin, M.D.
Oscar Dashef, M.D.
John E. Farley, M.D.
William L. Leet, M.D.
Robert M. Lord, Jr., M.D.
Betty Mathieu, M.D.
Frederick A. Peirce, M.D.
Lee G. Sannella, M.D.
William P. Shields, M.D.
Wilson Utter, M.D.

Diabetes Committee

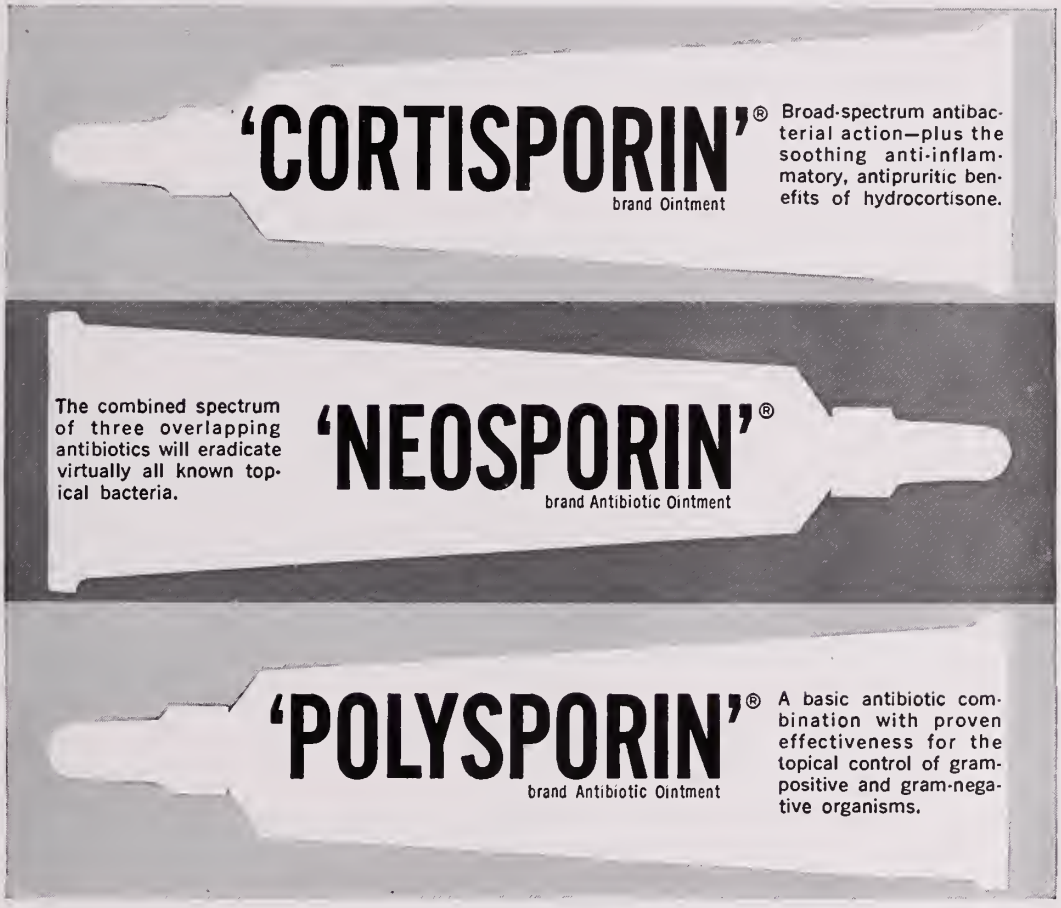
William L. Leet, M.D., *Chairman*
Rocco Abbate, M.D.
John M. Bleyer, M.D.
Charles W. Cashman, Jr., M.D.
Philomen Ciarla, M.D.
Alton Curran, M.D.
Charles Does, M.D.
Peter Erinakes, M.D.
Janis Gailitis, M.D.
Louis I. Kramer, M.D.
John J. Lury, M.D.
Thomas Murphy, M.D.
Alton M. Paull, M.D.
Amy Russell, M.D.
Albert F. Tetreault, M.D.
Salvatore Turco, M.D.

Disability Compensation Committee

Joseph C. Johnston, M.D., *Chairman*
E. Arthur Catullo, M.D.
Oswald Cinquegrana, M.D.
Joseph N. Corsello, M.D.
Thomas J. Dolan, M.D.
John J. Donnelly, M.D.
Henry Fletcher, M.D.
Americo A. Savastano, M.D.
Bencel Schiff, M.D.
Richard P. Sexton, M.D.
Stanley Sprague, M.D.
Anthony Verrone, M.D.
Joseph E. Wittig, M.D.

concluded on page 398

'B. W. & Co.' 'Sporin' Ointments rarely sensitize . . . give decisive bactericidal action for most every topical indication



Contents per Gm.	'Polysporin'®	'Neosporin'®	'Cortisporin'®
'Aerosporin'® brand Polymyxin B Sulfate	10,000 Units	5,000 Units	5,000 Units
Zinc Bacitracin	500 Units	400 Units	400 Units
Neomycin Sulfate	—	5 mg.	5 mg.
Hydrocortisone	—	—	10 mg.
Supplied:	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of ½ oz. and ⅛ oz. (with ophthalmic tip)

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

If you have patients on a cholesterol depressant diet, this will be welcome news:

General Mills is now making available, through grocery stores, a Safflower Oil which is totally acceptable in the diet, and which is priced reasonably.

SAFF·O·LIFE
Safflower Oil



As you know, Safflower Oil is higher in poly-unsaturates and lower in saturated fats than any other type of readily available vegetable oil.

When an increased poly-unsaturated fatty acid intake is desirable, you can recommend Saff-o-life Safflower Oil. You can do so with the assurance that the patient will find it completely appetizing—clear, light and fresh-smelling—and priced at a level which poses no problem.

Ratio of Linoleates* to Saturates
*(Poly-Unsaturates)

SAFFLOWER OIL • 9.0 to 1.0
CORN OIL • 5.3 to 1.0
SOYBEAN OIL • 3.5 to 1.0
COTTONSEED OIL • 2.0 to 1.0
PEANUT OIL • 1.6 to 1.0

Physicians who wish recipes using Saff-o-life Safflower Oil are invited to write directly to General Mills, Inc. Address your inquiries to Professional Services Director, General Mills, Inc. Dept. 120, 9200 Wayzata Blvd., Minneapolis 26, Minnesota.



For peptic ulcer gastric hyperacidity and gastritis...

In year-long study on peptic-ulcer patients

New Creamalin®
Antacid Tablets

*"...faster in onset of action...and for a longer period"**

"Clinical studies in 85 patients with duodenal ulcer ...confirmed the superiority of the new preparation [new Creamalin] over standard aluminum hydroxide preparations, in that prompt relief was achieved and maintained throughout the period of observation."*

Patients were followed for about one year.

New Creamalin promotes ulcer healing, permits less frequent feedings because it is so long-acting. Heartburn and epigastric distress were "...easily and adequately controlled...."* New Creamalin has the therapeutic advantage of a liquid antacid with the convenience of a palatable tablet. *It does not cause constipation.*

Each new Creamalin tablet contains 320 mg. of specially processed highly reactive dried aluminum gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. Minute particles offer a vastly increased surface area.

Dosage: Gastric hyperacidity—from 2 to 4 tablets as needed. Peptic ulcer or gastritis—from 2 to 4 tablets every two to four hours. *How Supplied:* Bottles of 50, 100, 200 and 1000.

Now also available—New Creamalin Improved Formula Liquid. Pleasant mint flavor—creamy pink color. Stabilized reactive aluminum and magnesium hydroxide gel (1 teaspoon equals 1 tablet). Bottles of 8 and 16 fl. oz.

Creamalin, trademark reg. U.S. Pat. Off.

*Schwartz, I. R.:
Current Therap. Res. 3:29, Feb., 1961.

Winthrop LABORATORIES New York 18, N.Y.

THE WASHINGTON SCENE

A Report Prepared by the Washington Office of the American Medical Association

THE AMERICAN MEDICAL ASSOCIATION endorsed in principle the Kennedy Administrations proposed mass immunization program, but urged three important changes.

Doctor F. J. L. Blasingame, executive vice president of A.M.A., outlined the A.M.A.'s position in a letter to Rep. Oren Harris (D., Ark.), chairman of the House Commerce Committee which held hearings on the Administration legislation (H.R. 10541) Doctor Blasingame said:

"The American Medical Association endorses the principle of H.R. 10541 as applied to the four infectious diseases named in the bill — poliomyelitis, diphtheria, whooping cough and tetanus — but urges that: (1) the bill be limited to the four named diseases; (2) the bill be financed as a grant-in-aid program with the states participating on a matching formula basis; and (3) the programs be administered by state health departments, preserving the well-established and accepted relationships between the United States Public Health Service and the states in matters pertaining to health."

The Committee accepted two of the changes proposed by the A.M.A. — that the program be limited to the four specified diseases and administered by state health departments. The bill then was passed by the House and sent to the Senate where it promptly received approval of the Senate Labor and Public Welfare Committee.

The bill would authorize federal grants to states and their political subdivisions for "intensive community vaccination" programs against the four diseases during the next three fiscal years. It would authorize $14 million for grants in the first year of operation and $11 million annually for the following two years. The federal funds would be used to purchase vaccine for children under age five, and for salaries and related expenses of the state and local immunization programs.

"Our House of Delegates has on many occasions adopted policy resolutions urging immunization against polio, tetanus, and other communicable diseases for which vaccine exist," Doctor Blasingame said. "Although traditionally it has been the policy of the American Medical Association to urge that the best means of administering vaccines is in the doctor's office, with the family physician vaccinating his patients, we also have recognized that intensive immunization against communicable disease is a public health matter."

* * *

The Public Health Service called on physicians to co-operate with community health officials and voluntary health agencies in launching in September a campaign to vaccinate pregnant women, persons suffering chronic debilitating diseases and the general population over age 45 against Asian influenza.

Surgeon General Luther L. Terry of the PHS urged that as many persons in these groups as possible be protected with one shot, or two if they are prescribed, before winter.

The call for the vaccination campaign was issued after a special advisory group warned that another wave of Asian influenza is due in the United States. The committee said that while accurate predictions are difficult, recent and past patterns of influenza A2 (known as the Asian strain) indicate it probably will occur throughout the nation this winter. The committee said indications were that influenza B would be infrequent.

The committee also recommended that serious consideration be given to immunizing persons in medical and health services, public safety, public utilities, transportation, education and communications fields. Doctor Terry said large scale immunization should be encouraged also in other industries and large institutions where absenteeism is of particular concern.

Previous campaigns included all persons over 65, but the age limit was lowered after study of past outbreaks.

Manufacturers of influenza vaccine were asked to estimate the amount of vaccine that would be needed and to have an adequate supply ready.

* * *

The Federal Radiation Council said that indications are that radiation received by the average American from nuclear testing is "considerably less than the exposure from natural sources."

But, in a major policy statement, the Council conceded that there is little scientific data to back up this conclusion and that it is difficult to be precise in this field.

"While a considerable body of information has been accumulated on the effects of radiation on animals and man, the possible effects of low doses delivered at low dose rates are insufficiently known to permit firm conclusions about the extremely low exposures resulting from fallout," the Council said in a report, "Health Implications of Fallout from Nuclear Weapons Testing Through 1961."

consider
the convenience
to pregnant
women of
a tablet this size



ENGRAN

Squibb Vitamin-Mineral Prenatal Supplement

FORMULA SUPPLIES 45 MG. OF IRON – AT NO EXTRA COST

The size of a prenatal vitamin-supplement tablet is important—the nausea and gastric distress often associated with pregnancy may make swallowing *anything* a real problem. Hence the small size of the Engran tablet is a great convenience to your pregnant patient, for Engran is actually the *smallest* tablet now available for prenatal vitamin-mineral supplementation. Yet only *one Engran tablet* a day will provide all these vitamins and minerals to help assure a nutritionally perfect pregnancy –

Vitamin A 5,000 U.S.P. units; vitamin D 500 U.S.P. units; thiamine 3 mg.; riboflavin 3 mg.; pyridoxine 2 mg.; vitamin B_{12} 2 mcg.; niacinamide 20 mg.; calcium pantothenate 5 mg.; vitamin C 75 mg.; calcium 100 mg.; iron 45 mg.; iodine 0.15 mg.; copper 1 mg.; magnesium 6 mg.; zinc 1.5 mg.; manganese 1 mg.

For full information see your Squibb Product Reference or Product Brief.

SQUIBB *Squibb Quality—the Priceless Ingredient*

Engran® is a Squibb trademark

SQUIBB DIVISION Olin

APPOINTED COMMITTEES, 1962-1963 – RHODE ISLAND MEDICAL SOCIETY

concluded from page 392

Disaster Committee

Francis E. Hanley, M.D., *Chairman*
G. Edward Crane, M.D.
Joseph E. Donahue, M.D.
Robert W. Drew, M.D.
Stanley Freedman, M.D.
J. Merrill Gibson, M.D.
William A. McDonnell, M.D.
James B. Moran, M.D.
Philip J. Morrison, M.D.
Francis W. Nevitt, M.D.
Frank A. Racioppi, M.D.
Joseph L. Ruisi, M.D.
Alfred Tartaglino, M.D.

Highway Safety Committee

John A. Dillon, M.D., *Chairman*
Edward J. Butler, M.D.
Taras Hanushevsky, M.D.
H. Raymond McKendall, M.D.
Thomas C. McOsker, M.D.
Thomas Nestor, M.D.
Robert E. Newhouse, M.D.
Nathaniel D. Robinson, M.D.
Julius Stoll, M.D.
Frederick Webster, M.D.

Maternal Health Committee

Stanley Davies, M.D., *Chairman*
Harold L. Beddoe, M.D.
J. Kenneth Beezer, M.D.
Bertram H. Buxton, Jr., M.D.
John E. Carey, M.D.
Francis V. Corrigan, M.D.
Guyon Dupre, M.D.
Walter R. Durkin, M.D.
Herbert Ebner, M.D.
Louis J. Fuhrmann, M.D.
Louis A. La Pere, M.D.
William J. MacDonald, M.D.
William A. Reid, M.D.
Frederic W. Ripley, M.D.
Henry E. Turner, M.D.

Mental Health

Harold W. Williams, M.D., *Chairman*
David J. Fish, M.D.
Charles C. Goodman, M.D.
Hugh Kiene, M.D.
Maurice Laufer, M.D.
Neida Q. Ogden, M.D.
Laurence Senseman, M.D.
Louis V. Sorrentino, M.D.
Hugo Taussig, M.D.
Joseph S. Zucker, M.D.

Medical Advisory Committee to National Foundation

Raymond L. Trott, M.D., *Chairman*
Thomas L. Greason, M.D.
Clara L. Smith, M.D.

Perinatal Mortality Committee

Bertram H. Buxton, Jr., M.D., *Chairman*
D. William J. Bell, M.D.
George Anderson, M.D.
John Carey, M.D.
Francis V. Corrigan, M.D.
Stanley Davies, M.D.
Eric Denhoff, M.D.
Herbert Ebner, M.D.
John P. Grady, M.D.
Thomas F. Head, M.D.
Gilbert Houston, M.D.
Maurice N. Kay, M.D.
Earl F. Kelly, M.D.
William McDonnell, M.D.
Sumner I. Raphael, M.D.
William A. Reid, M.D.

Committee on Medical Aspects of Sports

Americo A. Savastano, M.D., *Chairman*
G. Edward Crane, M.D.
Joseph Donahue, M.D.
Charles J. Hutchinson, M.D.
Edwin B. O'Reilly, M.D.
William J. Schwab, M.D.
Salvatore Turco, M.D.

Science Fair Committee

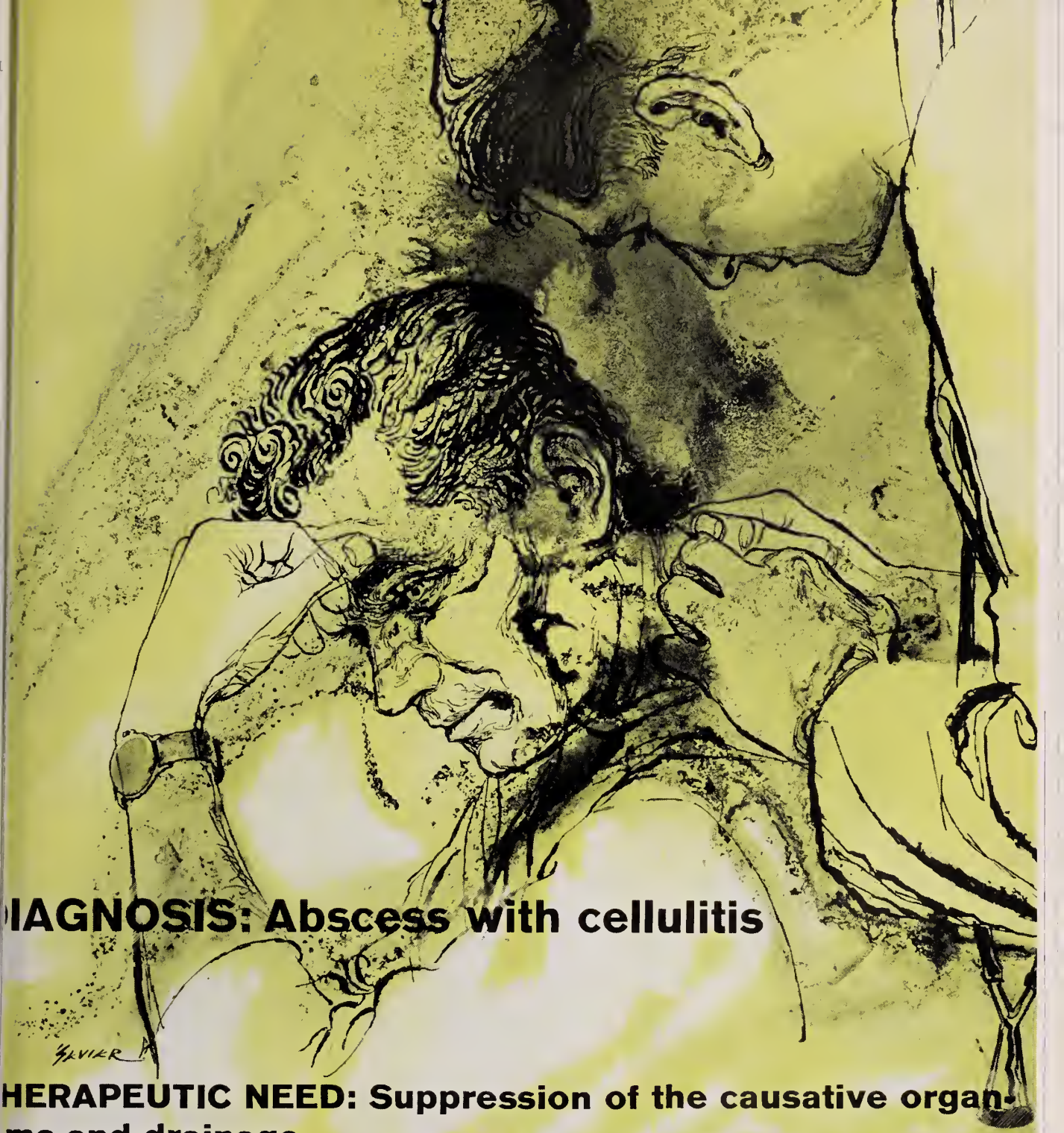
Charles L. York, M.D., *Chairman*
Leland L. Jones, M.D.
Lester L. Vargas, M.D.

Social Welfare Committee

Peter L. Mathieu, Jr., M.D., *Chairman*
Anacleto Berrillo, M.D.
Joseph Dowling, Jr., M.D.
Donald P. Fitzpatrick, M.D.
Henry W. Joyce, M.D.
Earl J. Mara, M.D.
Gustavo A. Motta, M.D.
Samuel Nathans, M.D.
Hossein A. Shushtari, M.D.
Leonard Sutton, M.D.

Advisory Committee to Woman's Auxiliary

Albert H. Jackvony, M.D., *Chairman*
Samuel Adelson, M.D.
Robert R. Baldridge, M.D.
Earl J. Mara, M.D.



IAGNOSIS: Abscess with cellulitis

**HERAPEUTIC NEED: Suppression of the causative organ-
ms and drainage.**

NTIBIOTIC: DECLOMYCIN®

Demethylchlortetracycline Lederle

**ecause it has been proved clinically effective in abscess
nd other soft-tissue infections.**

uest complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

DERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York Lederle

LOMOTIL®

(brand of diphenoxylate hydrochloride with atropine sulfate)



ANTIDIARRHEAL TABLETS and LIQUID

lowers motility / relieves cramping / controls diarrhea

Roentgenographic studies by Demeulenaere[1] established that a single dose of 10 mg. of Lomotil slowed gastrointestinal transit within two hours and that it maintained its decelerating activity for more than six hours.

In diarrhea this lowered propulsion permits a physiologic absorption of excess fluid, lessens frequency and fluidity of stools and gives safe, selective, symptomatic control of most diarrheas. Concurrently, it conserves electrolytes and controls cramping.

Investigators have found the antidiarrheal action of Lomotil not only "excellent"[2] but "efficacious[3] where other drugs have failed. . . ."

DOSAGE: For *adults* the recommended initial dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is under control. Maintenance dosage may be as low as two tablets daily. For *children* daily dosages, in divided doses, range from 3 mg. (½ teaspoonful three times daily) for infants 3 to 6 months to 10 mg. (1 teaspoonful five times daily) for children 8 to 12 years. Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg. and as liquid containing 2.5 mg. in each 5 cc. A subtherapeutic amount of atropine sulfate (0.025 mg.) is added to each tablet and each 5 cc. of the liquid to discourage deliberate overdosage. The recommended dosage schedules should not be exceeded.

NOTE: Lomotil is an exempt narcotic preparation.

Descriptive literature and directions for use detailed in Physicians' Product Brochure No. 81 available from G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.

1. Demeulenaere, L.: Action du R 1132 sur le transit gastrointestinal, Acta Gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.
2. Kasich, A. M.: Treatment of Diarrhea in Irritable Colon, Including Preliminary Observations with a New Antidiarrheal Agent, Diphenoxylate Hydrochloride (Lomotil), Amer. J. Gastroent. 35:46-49 (Jan.) 1961.
3. Weingarten, B.; Weiss, J., and Siman, M.: A Clinical Evaluation of a New Antidiarrheal Agent, Amer. J. Gastroent. 35:628-633 (June) 1961.

G. D. SEARLE & CO.

Research in the Service of Medicine

The RHODE ISLAND MEDICAL JOURNAL

VOL. XLV AUGUST, 1962 NO. 8

The Fifth Murray S. Danforth Oration

CONGENITAL MUSCULAR TORTICOLLIS

Hematoma, Fact or Myth

GEORGE J. GARCEAU, M.D.

The Author. *George J. Garceau, M.D., of Indianapolis, Indiana. Professor of Orthopedic Surgery and Head of the Orthopedic Department, Medical School of the University of Indiana.*

THE INVITATION to deliver the Fifth Murray S. Danforth Oration is a singular honor which you have bestowed upon me. For this I wish to thank all of you. I knew Doctor Danforth from a distance as a young man looks up to his illustrious elders. I realized that he had a wide interest in our specialty and knew of his profound concern with the care of crippled children. The latter compelled the choice of the subject I shall discuss—*Congenital Muscular Torticollis, Hematoma, Fact or Myth.*

The term congenital muscular torticollis implies that pathology exists in the sternocleidomastoid muscle prior to and after birth. Torticollis associated with osseous malformations, neurogenic factors, ocular and other entities are excluded from this discussion because the torticollis therewith is a symptom of abnormalities remote from the sternocleidomastoid muscle.

Etiology

The etiology of congenital muscular torticollis continues to be obscure. Eight textbooks on orthopaedic surgery continue the habit of being all-inclusive in the classification of the etiology. All texts mention or discuss the theory of faulty position in utero, injury during birth, hemorrhage and hematoma, as possible causes. The theory of ischemia is mentioned frequently and recently revived. However, no one has satisfactorily explained how these theories account for the changes which are found in the tumor in the sternocleidomastoid muscle. All authors agree that the mass is composed of fibrous tissue. The cause of the fibrosis remains a mystery.

Theory of Faulty Position in Utero

The theory of faulty position in utero is the oldest theory concerning the cause of muscular torticollis. The theory is based entirely on speculation. It is just as reasonable to speculate and arrive at opposite conclusions. Every newborn infant demonstrates positional attitudes especially of the limbs. The hips and knees are flexed but correct spontaneously. A similar postural attitude of the head and neck should correct in like manner rather than becoming worse. Many of these do become worse and develop the typical deformity of torticollis. Young tissues which have contracted because of immobilization usually correct rapidly with or without passive stretching. Furthermore no mass is found in other muscles which resemble that found in the sternocleidomastoid muscle. Hypertrophic pyloric stenosis is discovered at about the same age, but it is a hypertrophy of smooth muscle and not a replacement of muscle fibers. A great amount of information, based on direct observation, is recorded in the literature. None of this information can be applied to support the theory of faulty position in utero. If conjecture is to judge on incomplete evidence then the theory of faulty position in utero is not tenable.

Theory of Trauma, Hemorrhage and Hematoma

Stromeyer,[15] in 1838, proposed and supported the theory of trauma during the birth which produced a hematoma. The mass which was visible and palpable was interpreted by Stromeyer to be a hematoma. Stromeyer's interpretation of the nature of the mass was pure speculation. Many reports in the literature disprove the theory.

In 1883, Witzel[17] concluded that experimental tears of the sternocleidomastoid muscle in rabbits left no contractures which resembled that of congenital muscular torticollis.

Heller,[3] in 1898, failed to produce contractures of muscles in dogs by traumatization except when infection accompanied the trauma.

Many years ago, in a study of experimental shock, we produced extensive trauma to the muscles of the legs of dogs. In no instance did we observe fibrosis which in any way resembled that found in congenital muscular torticollis.

continued on next page

*Delivered at Providence, Rhode Island, October 5, 1961.

Bradford and Lovett,[1] 1899, produced hematoma in the sternocleidomastoid muscles of rabbits and reported negative results. They further reported that birth injury to the muscle in infants did not result in torticollis. Nevertheless, the 1929 edition of *Orthopaedic Surgery* by Jones and Lovett[6] stated that trauma and hematoma are causes of torticollis. Authors of our current textbooks continue to include trauma, hemorrhage and hematoma as causes of congenital muscular torticollis. Clinical observation and laboratory experimentation fail to support the theory of trauma, hemorrhage and hematoma. The theory is entirely speculative.

Theory of Ischemia of Muscle

In 1895, Mikulicz[11] suggested that ischemia was the cause of the fibrosis in the muscle. He postulated that the combined extension and rotation of the head and neck in the birth canal caused trauma to the muscle, and that compression on the umbilical cord increased the ischemia.

In 1906, Nove-Josse and Vianny[12] injected the arteries to the sternocleidomastoid muscle in twenty stillborn infants. These experiments were conducted with the infant head in various positions. They concluded that, with the head in extreme rotation, the sternocleidomastoid muscle was rendered taut and thus caused ischemia. They postulated that this position simulated that of the foetal head in the birth canal during parturition. This theory appears to merit consideration. It does not support the theory of hematoma as the cause of the tumor.

In a personal communication (1961) Shellhamer,[14] a professor of anatomy at the Indiana University School of Medicine, postulates that the ansa cervicalis nerve, as it loops around the sternocleidomastoid artery, could compress the artery when the head is in extreme rotation. This would presuppose that partial and temporary ischemia produces changes caused by complete arterial obstruction. How long must partial and temporary arterial obstruction be in effect to produce the changes found in the nodule of congenital muscular torticollis? Animal experiments are necessary to render this combination theory tenable.

Endogenous Theory

In 1924, Krogius[8] suggested that the cause of congenital muscular torticollis was endogenous in nature. He believed it was a congenital defect in the muscle. This theory has not been proven. However there are many cases reported in the literature which had other associated congenital deformities. In our series there are four patients with associated deformities which required treatment. In addition, the father of one patient had an uncorrected torticollis. The maternal uncle of another patient had a torticollis. A brother of one of our patients had bilateral supernumerary toes. These observations prove nothing, but do supply reason for speculation. We personally subscribe to this theory.

Pathology

The gross and microscopic pathology of the tumor of the fibrous cord which may result from the tumor is well described by several articles in the literature. Reference to a few such articles appears apropos at this time.

The first description of the gross and microscopic characteristics was published by Frederick Taylor[16] in 1875. He stated that fibrous tissue formed between the muscle fibers, displacing and destroying the muscle fibers. He reported that within the nodule no striated fibers could be seen. This description of the gross and microscopic appearance is about the same as that of the pathologist of today.

Parker,[13] in 1893, cut into the swelling in the sternocleidomastoid of a five-week-old infant and found no evidence of blood or pigment. In 1895, Mikulicz[11] studied the muscle in twenty-one infants and found only fibrous tissue replacing the muscle fibers. Heusinger,[4] in 1905, found no trace of hematoma in the mass in the muscle of a fourteen-day-old infant. Middleton,[10] in 1930, stated that the mass resembled a soft fibroma. Microscopic examination of the mass revealed young and cellular fibrous tissue and residual degenerating muscle fibers.

In 1931, Holloway[5] performed an operation upon a twelve-day-old infant and found the muscle fibers to be replaced by fibrous tissue. In a seven-week-old child he found a greater degree of fibrosis. In 1944, Chandler and Altenberg[2] found fibrous tissue replacement of muscle fibers. The few remaining muscle fibers were in various degrees of degeneration. As recently as 1955, Kiesewetter[7] gave further support to the observations of previous authors.

In an extensive review of the literature by Lidge, Bechtol, and Lambert[9] published in 1957, no evidence is found in support of the theory of trauma and hematoma as a cause of the pathology.

Our unpublished observations, now complete in twenty cases, agree entirely with the published reports.

Discussion of the Pathology

Living tissues are undergoing a constant change. These changes may be those associated with aging or abnormal phenomenon. The mass found in the sternocleidomastoid muscle in an infant is no exception. The muscle mass increases in size for a period of three to six weeks, then it gradually decreases in size and finally disappears between the fourth and sixth month of life. There are two definite patterns of progress. The sternocleidomastoid muscle may be restored to normal, or may in great

part be replaced by fibrous tissue. When the fibrosis persists it becomes more mature. The normal elasticity of the muscle is lost, thus producing so-called congenital muscular torticollis.

Personal Observations

In preparation for this communication, the first twenty cases selected for resection of the tumor were studied. The youngest was eighteen days of age when operated upon and the oldest was eight months of age. One patient, operated on at the age of three years, is added for contrast.

All of the tumors, when exposed, presented a similar appearance. The mass usually occupied the middle third of the muscle and involved the sternal head of the muscle most frequently. A small mass on the clavicular head was found a few times. The masses were fusiform in shape, hard or firm in consistency, and glistening on the surface. In some there was a thin layer of muscle on the surface of the mass. The ends of the masses appeared to fuse with the muscle. The tissue cut with a feeling of firmness and crepitation. The cut ends were white and were interspersed with areas of red muscle fibers. The blood supply appeared adequate and bleeding was free. In no instance were signs of trauma observed.

The microscopic sections revealed an abundance of a young fibrous tissue and varying amounts of degenerating muscle fibers. In the very young infants the tumor was composed of proliferating fibroblasts which invaded the muscle mass and appeared to separate the fibers from one another. Edema between the muscle fibers was found in some cases. No microscopic evidence of trauma or hemorrhage was found. The microscopic picture of all the sections was remarkably constant, although the degree of fibrosis varied.

Case Reports

Two of the following case reports are typical of those operated upon early in infancy. The third case report is typical of fully developed torticollis at the age of three years.

Case 1. J. L., white male infant, born by normal cephalic delivery, December 21, 1957. The father, a senior medical student, noted the mass in the left sternocleidomastoid muscle soon after birth. This infant was examined on the third day of life. Subsequent examinations revealed the gradual increase in the size of the tumor. The left side of the face and the right occipital region became flattened. On January 8, 1958, eighteen days after birth, a resection of the mass was performed. Some normal muscle fibers were found on the surface of the mass and these were preserved. A mass 2.5 cm. x 1.5 cm., and a smaller nodule .8 cm. x .5 cm. x .3 cm. were removed. These masses cut with the consistency of fibrous tissue.

The pathologist's report reads as follows:

"MICROSCOPIC: Sections of the nodule from the neck show it is composed of masses of skeletal muscle. The skeletal muscle fibers show considerable size variations. Some bundles are present in which the cytoplasm of the muscle fibers is sparse. There is rather pronounced overgrowth of fibrous connective tissue. The fibrous tissue is cellular and in some areas has caused partial destruction of the muscle fibers."

The gross and microscopic examination of the tumor revealed no signs of trauma, hemorrhage or hematoma.

Case 2. S. L., a white male infant born by cephalic presentation on October 16, 1958. This infant was first observed on the day of birth because of severe congenital talipes calcaneovalgus. It was noted that the head was turned to the right. The neck was carefully examined by two examiners. There was no signs of trauma such as discoloration, swelling or tenderness. No mass could be felt. No contracture was detected. On November 8, 1958, when the baby was 22 days old, a mass was noted in the left sternocleidomastoid muscle. There was a mild asymmetry of the head and face. The face was kept turned to the right. On November 29, 1958, the mass was larger than when first seen, and there was definite contracture of the muscle. The deformity of the head was now apparent. On December 12, 1958, masses were removed. The larger mass was in the sternal head of the muscle. No evidence of trauma or hematoma was observed.

continued on next page



FIGURE 1

White male infant, 6 weeks old. The largest tumor removed (photo in reverse).

FIGURE 2

Same infant as in Figure 1. Note excoriation of the skin in the fold of the neck below the tumor (photo in reverse).

The pathologist's report reads as follows:

"1. Consists of a grayish to dusky red section of soft tissue which measures 3 cm. x 1.5 cm. x 9 cm. On sectioning the specimen is noted to be dense gray tissue which has the characteristics of fibrous tissue.

"2. Specimen consists of similar appearing section of soft tissue which measures 2 cm. x 1.25 cm. x 0.75 cm."

"MICROSCOPIC: 1. The section shows widely scattered skeletal muscle fibers separated by dense fibrous tissue. Many of the muscle fibers stain poorly. The tissue is well vascularized and numerous small vessels with prominent endothelial lining are present. Some areas of extravasation of red cells are present but no hemosiderin or macrophage response is evident." Note that the pathologists stated "no hemosiderin or macrophage response is evident."

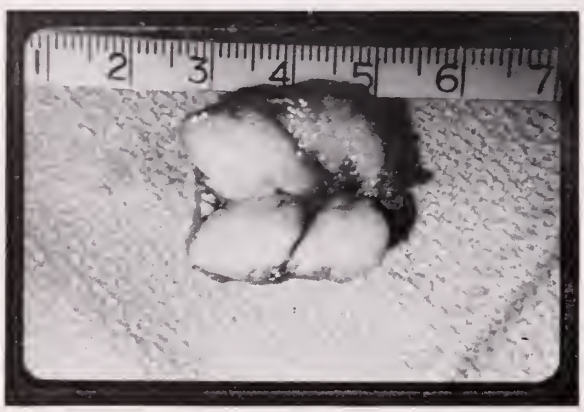


FIGURE 3

Tumor cut in half. Note the glistening out surface. Mass consists of fibrous tissue.

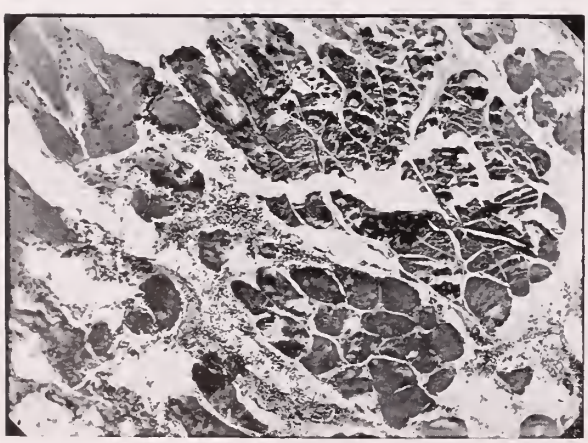


FIGURE 4

Microscopic section photomycrograph (X 100). Note areas of degenerated muscle fibers. Cross section of some bundles appear to be normal, others in process of degeneration.

Case 3. C. D. D., a white, eleven-week-old male infant first examined on March 13, 1950, for congenital dislocation of the left hip. The physical examination revealed a left muscular torticollis. The left sternocleidomastoid muscle was enlarged but did not have the typical fusiform mass. The parents were taught the manipulations which were performed very faithfully until the age of three years. The characteristic deformity persisted. Only the clavicular head of the muscle was involved, a rather unusual feature. On November 11, 1953, section of the clavicular head of the muscle was performed. A section of the muscle was removed for microscopic examination.

The pathologist's report reads as follows: "Specimen consists of 2 portions, one of which is 2.25 cm. x 1 cm. x 0.5 cm. It appears to be made up of muscle fibers, in the middle portion of which there is a firm nodule. The muscle itself is reddish brown in color, and trabeculated. The nodule measures 8 mm. x 5 mm. On cut section a glistening, flat, finely trabeculated out surface is noted."

"MICROSCOPIC: Sections of the muscle submitted demonstrates muscle fibers separated from one another by an abundant fibrous connective tissue substance that appears fairly mature. The other nodule submitted is composed of irregular interlacing bundles of collagen that suggests the appearance of a tendon."

In this case evidence of persistence of a residuum from the nodule is reported. Unfortunately, we have no specimen of a muscle in which the mass had disappeared and left no deformity.

Conclusion

1. The theory of simple faulty position in utero, as a cause of congenital muscular torticollis, is not supported by the evidence available.

2. The theory of trauma, hemorrhage, and hematoma is not supported by clinical observation nor by animal experimentation.

3. A hematoma has never been observed to produce torticollis.

4. The theory of ischemia, partial and temporary, of the lower two thirds of the sternocleidomastoid muscle, and the roll of the ansa cervicalis nerve deserves further investigation.

5. The theory of trauma, hemorrhage, and hematoma should be removed from textbooks.

6. The hematoma theory appears to be a myth.

Bibliography

[1]Bradford, E. H., and Lovett, R. W.: Treatise on Orthopedic Surgery, Ed. 2, New York, William Wood and Company, 1899

[2]Chandler, F. A., and Altenberg, Alfons: "Congenital" Muscular Torticollis. J. Am. Med. Assn., 125:476-483, 1944

[3]Heller, Moritz: Experimenteller Beitrag zur Aetiologie des Angeborenen muskularen Schiefhalses. Deutche Zeitschr. f. Chir., 49:204-241, 1898

concluded on page 414

PREVENTION—A CHALLENGE TO THE MEDICAL PROFESSION*

AARON W. CHRISTENSEN, M.D.

The Author. *Aaron W. Christensen, M.D., of Washington, D.C. Assistant Surgeon General, Associate Chief for Community Health, Bureau of State Services, United States Public Health Service.*

I FEEL PARTICULARLY FORTUNATE to have the honor of representing Doctor Luther Terry, Surgeon General of the Public Health Service, because the programs which I am supervising in our Bureau of State Services are the ones that deal most directly with the topics of this conference. We need the thinking and the suggestions of groups like this to help us improve these programs. Consequently, I am going to take advantage of this opportunity to pose various questions in the hope that as possible answers occur to you, you will pass them on to us.

The make-up of this conference, including as it does private practitioners and public health officials, is of itself a recognition that the lines which used to separate private and public medicine have disappeared. More and more in the future, I believe and hope we will find this mixture of practitioners and health officials at all medical and public health events. For it is only by working together that we can forge new patterns of care to meet the newly emerging problems of health.

The need for private-public partnership is particularly apparent in dealing with the problem of preventing disability. And incidentally, I was pleased to see that the very name of this conference puts the accent on *prevention*. Today, most work in rehabilitation involves attempts to reverse existing disabilities, a very high percentage of which could have been prevented in the first place. How can we change this picture? What can the private physician do? What can the public health officials do to help him?

Let us consider first the private physician's role. For purposes of illustration, I will discuss it in terms of a hypothetical patient with rheumatoid arthritis. Pain and inflammation are what prompted the patient to seek medical attention and it is a temptation to the busy physician to treat him at that level — merely prescribing the drugs that will reduce the inflammation and relieve the pain. To do so, however, is to miss the best opportunity for prevention and to start a chain of events that may eventually bring the patient — by this time severely crippled — back for restorative services.

If prevention is our goal, we must deal at the outset, not merely with the symptoms but with the patient as a whole. Does he understand the importance of exercises? Is he motivated to keep at them regularly, no matter how painful they may be? As the drugs relieve his discomfort, will he slip back to the old habits? How can follow-up be assured?

For the private physician, time is money and the management of the arthritic patient from a preventive standpoint is a long, time-consuming process of education and counseling.

Similarly with the diabetic patient, studies in well-ordered clinics indicate that these patients need at least eight hours of instruction.

Go down the list of chronic ills — stroke, heart diseases, arteriosclerosis — all call for a variety of time-consuming services to prevent disabilities which are not inherent in the disease itself, but are commonly associated with it. The patients who fill our rehabilitation clinics are tragic evidence that not enough preventive services are reaching enough patients early enough.

Obviously some essential element is missing — one which few private physicians have time to provide. That is why I suggested at the outset that private-public partnership may be the answer. Once the physician has planned the management of his case from a preventive standpoint, it would seem quite feasible for a progressive public health program — and here in Rhode Island with your new director of Health, Doctor Cannon, you know that you can count on progressive public health leadership — to help the physician reduce the time he needs to spend in dealing with the preventive aspects of chronic disability. Use of ancillary personnel, of self-help material for patients — such as the exercise booklets for stroke and arthritis which the Public Health Service has issued — these are suggestive of ways private physicians and public health workers can collaborate on these problems.

Perhaps the first and crucial step toward pro-

continued on next page

*Keynote address delivered at the Conference on the Prevention of Disability, at Providence, Rhode Island, November 29, 1961.

ductive partnership is recognition that the prevention of disability calls for skills and services beyond those which the physician personally can supply. The nurse, the social worker, the nutritionist, the many types of therapists — speech, physical, occupational, and others — the homemaker, the nurse's aide — all of these and many others have a role in the prevention of chronic disability.

How do we co-ordinate these services? How can we provide them to the patient who is in his own home or in a nursing home as well as to patients in hospitals?

Modernizing Health Care Patterns

These unresolved questions point up a deeper problem — the problem of how to modernize patterns of health care. Through research, we now possess hitherto undreamed of powers to prevent disease, to retard its progress, and to alleviate its handicapping effects. How to apply this knowledge fully remains, however, a relatively unsolved problem.

As a result of this failure of application, it is estimated that half to three quarters of the people with chronic diseases or disabilities are more handicapped than they need to be; that a million people each year suffer from diseases and disabilities that are entirely preventable, and that some 150,000 fatalities that occur each year could have been averted.

Examined superficially, one might conclude that this appalling loss of health and life is an indictment of our profession; that some of us are failing to do our duty. I wish it were so simple. We could then find the guilty ones and take them to task. But who are the guilty? There may be private practitioners who neglect their patients, but certainly they are rare. There may be inefficient public health physicians, but I do not know them. On the contrary, one gains the impression that both physicians and health officials are working, and overworking, conscientiously and intelligently.

The more one studies the problem, the more it appears that the difficulty may lie less in our professional shortcomings (though being human, we have them too) than in the organizational patterns which control our mode of work. When we shifted from the horse and buggy to car transportation, we substituted superhighways for rutted dirt roads, but when we shifted from the horse and buggy doctor to the modern man of medicine, we made only limited changes in our setting. True, the modern hospital is quite different from the nineteenth century pest house; the physician's office is modernly equipped; and some, though not enough, health departments are modernly staffed and equipped. Yet as evidenced by those appalling statistics I quoted earlier, we still have not achieved a pattern that assures everyone the services he needs when and where he needs them.

What are the shortcomings in our present patterns? Can we identify and correct them? These are the crucial questions I pose to you, for their answers must be found community by community, with private physicians and health officials leading in the search. To stimulate your thinking, however, let me throw out a few clues as I see them.

We have seen the need for new patterns in the management of chronic disability. Let us now consider how our present patterns appear to fail in the area of primary prevention. Back in the nineteenth century when our community patterns for providing health and medical services were established, our tools for primary prevention were few and crude. We knew that sanitation reduced the spread of filth-borne diseases and we set up health departments to enforce sanitation measurements. In all too many communities today, health departments have neither the staff nor the funds to do much more. Isolation of the patient was about the only other way, in those days, to cut the toll of communicable diseases. I can still recall the red and yellow measles and scarlet fever placards my father, a conscientious physician of his day, put religiously on each affected home.

But consider the tools for primary prevention we possess today: vaccines for smallpox, tetanus, diphtheria, whooping cough, polio and influenza, with measles vaccine just around the corner and, undoubtedly, still others to come. We have the tool of prophylaxis for prevention of rheumatic fever and rheumatic heart disease and, most recently, we have evidence that isoniazid prophylaxis is 80 per cent effective in reducing the incidence of tuberculosis among household contacts.

The private physician uses these preventive tools; they are among the routine services he offers his patient. A growing number of health departments include some of these immunizations as a part of the services of their well-baby clinics. Nevertheless, numerous surveys, some limited to polio immunization status and some more comprehensive, pile up evidence that at least half the children in this nation and probably a much higher proportion of adults are not adequately and currently immunized. A very sizable part of the population, for whatever reason, is not caught up by the immunization efforts of either the private physician or the health official and no other service is filling the gap.

We can say that every family ought to have a physician and ought to seek immunizations from him at the appropriate intervals. Or we can say that health departments, schools, or some other unit of the community ought to see that children, at least, are not burdened by diseases that are easily preventable. But "ought to" doesn't equal "is." The

hard cold fact remains that millions continue to risk diseases unnecessarily and tens of thousands continue to get those same diseases unnecessarily.

How can we close that gap? I haven't an answer, and I don't suppose you have but, as the list of preventive agents grows, the demand for an answer will become more insistent. If the medical profession, which is the best qualified to do so, does not come up with constructive proposals, others, less qualified, may well do so.

Areas of Secondary Prevention

Now let us move on to secondary prevention. How do our present health patterns fail to assure full application of knowledge in this area? Early diagnosis is the key element here. We all know that the toll of such diseases as diabetes, cancer, glaucoma, and syphilis could be greatly reduced — syphilis in fact could be eradicated — if all cases were found early and treated promptly.

Our present health patterns rely chiefly upon the patient himself aggressively seeking care. In the nineteenth century, when these patterns were formed, they worked fairly well. The acute diseases, which were then the major health problems, produced pronounced symptoms which clearly warned the patient he needed medical attention. Today, however, many of our most serious diseases give no warning symptoms at their early and most treatable stages. And too many people, at this stage of disease, are not seeking treatment. A fifth of all blindness results from glaucoma that was not diagnosed early enough. Cervical cancer takes the lives of 13,000 women annually, women who did not get the Pap smear test early enough. An estimated million and a half people who have diabetes do not know it — have never had a glucose test.

Here again, it is not sufficient that we have developed highly efficient tools for secondary prevention. So long as a sizable portion of the population fails to take advantage of them, we cannot be content. Developing a pattern that will bring the apparently well individual to treatment is admittedly a difficult task. But a profession ingenious enough to develop the modern medical armamentarium is surely ingenious enough to solve the problem of delivery of services.

Fortunately, in all of these areas of prevention, new approaches are being explored.

The community programs for polio vaccination may prove to be an early prototype of more effective patterns for assuring widespread use of agents for primary prevention. In the six years since polio vaccine became available, about 100 million persons have used it. Never before have so many people used a new preventive in such a short span of time.

In the areas of secondary prevention, educational efforts on the value of periodic medical check-ups are influencing an increasing number of people, particularly the middle aged and elderly in the higher income groups. Screening clinics offer promise as a means for early detection of disease symptoms among persons who would not normally consult a private physician and the number of diseases for which screening is practical is steadily increasing.

In this connection, we are watching with interest a Service-supported project involving the use of soft-tissue roentgenography for the detection of breast cancer at the M. D. Anderson Hospital and Tumor Institute in Houston, Texas. Results to date indicate that mammography may ultimately prove as effective in the early detection of breast cancer as cytology has proved to be in the early detection of cervical cancer. Evaluating the first 1,000 cases examined by X-ray at this institution, Doctor Rober Egan reports that mammography proved far more accurate than the palpatory method.

Certainly, we have a long way to go in improving our existing screening programs, let alone developing new ones such as the use of mammography. Moreover, there will no doubt always be diseases that do not lend themselves to screening, that can only be detected by a thorough diagnostic examination. Nevertheless, the improvement in diagnostic tools and the exploration of ways to use them more extensively are encouraging developments.

Encouraging also is the exploration of ways of co-ordinating the many and varied services which help to reduce disability among the chronically ill and aged. Right here in Providence, we have an interesting example. I refer to the Information Service for the Chronically Ill and Aged, established as a unit of the Rhode Island Council of Community Services. This service began in 1959 as a demonstration project made possible through a co-operative agreement by the Council, the Rhode Island Department of Health, and the Chronic Disease program of the U.S. Public Health Service. It is the purpose of the Information Center to co-ordinate the varied services a chronically ill patient needs which are available and also to highlight needs for which there are no available services so that efforts can be started to fill these service gaps.

Perhaps the best way to describe this service to those of you from outside the state who may not have heard of it is to cite an example of their work as described in their literature. This is a case story from one of their annual reports:

"Mrs. C., age 51, with a diagnosis of 'organic brain damage,' prognosis guarded, was referred by a psychiatrist for placement in supervised employment. We learned that several agencies had been involved superficially. Their facts were nebulous and therefore 'the case was closed.'

continued on next page

"The Information Service after extensive exploration and evaluation called a case conference, as no one would assume responsibility for aiding this patient. The physician attended the conference. As a result, it was determined that there was a resource available, for which the client was eligible, so as to evaluate her rehabilitation potential and make placement if indicated. The Information Service made the contact with the family to explain how they might follow through on the physician's recommendation with application to the proper community resource and pointed out why other resources were inappropriate. All of this might have been accomplished quickly and simply if this family knew where to turn in the first place. They had made a pilgrimage from agency to agency which resulted in confusion."

This type of referral and counseling service illustrates constructive, imaginative effort to close one of the gaps I've been discussing. Co-ordinated home care programs, both hospital and community based, are other examples.

They are all hopeful signs that we are groping our way to new community patterns of health care — patterns that do not leave people without care either because they do not seek it aggressively or because there is no service that meets their particular need.

But let's admit it, we are groping. We are still a long way from modern, comprehensive health care patterns which assure maximum use of preventive agents, early diagnosis and adequate treatment, and which provide the full gamut of restorative services — services which Doctor Daitz and others who follow me will discuss in more detail — to reduce disability among the chronically ill and aged.

Federal Health Legislation

It is because we recognize this that many of us have been very much encouraged and excited by certain health legislation passed by the Congress shortly before it adjourned this fall. I refer to the Community Health Services and Facilities Act.

This is in some respects an omnibus law, providing for many long needed improvements in federal health programs including more adequate support for schools of public health, a higher ceiling on federal funds for hospital research, more liberal terms for federal financing of rehabilitation facilities, more funds for nursing homes. The features of the act, however, which bear directly on the problems I have been discussing, are: first, additional grants to state health departments for the development of services for the chronically ill and aged; and second, the authorization of project grants to nonprofit agencies for research on methods of providing out-of-hospital services.

The grants to state health departments should prove a stimulant to the development of more Information and Referral Centers such as the one here in Rhode Island, more organized home care programs, more visiting nurse programs, homemaker services and other activities that have already proved their worth.

The project grants offer an even greater challenge. Their purpose is to foster studies, demonstrations, and experiments of NEW methods or improvements of existing methods of delivering health and medical services. Here is a real opportunity for any imaginative, creative, pioneer-spirited organization — state or local health department, medical society, civic group — *any* nonprofit group is eligible for this federal aid. Quite obviously, priority consideration will be given to projects which offer the best promise of closing the gap between what could be done and what is being done to prevent disease and disability.

The new law takes cognizance of the fact that, excellent as many of our health and medical services are for those who seek and use them, they are not meeting the needs of our aging, urbanized, highly mobile, and expanding population. A system that fails to prevent the unnecessary illness, disability, or death of millions of citizens is just not good enough for the wealthiest and most progressive nation in the world.

The new law also takes cognizance of the fact that effective improvements in the system are most likely to come from people who are closest to the problem — the practicing physician, the state or local health official, the nursing home operator, the welfare worker — in brief, the people who see and deal with the victims of our outmoded patterns. That is why this is set up as a grant program, not a federally operated program. The federal government's role is to help finance the innovations and to spread the word about the successful ones so that other states and communities can adopt them.

We feel that this latter function, of conveying information, is a particularly important responsibility of the Public Health Service. As research yields new tools for diagnosis and treatment as well as for methods of administering health and medical services, it becomes increasingly difficult for the physician, whether he is in private medicine or public health, to keep abreast. To help meet this problem, we are, as you know, sponsoring numerous conferences, seminars, training courses. We are also preparing various training materials, such as the *Strike Back at Stroke* and *Arthritis* booklets prepared by Doctor Daitz. We expect to do more soon in some fields where we have to date done relatively little — in such fields as vision control programs and medical care administration.

On this whole problem of how to help you get the new information you need in the way it will be

concluded on page 414

DOCTORS, INCORPORATED

CHARLES P. WILLIAMSON

The Author. *Charles P. Williamson, of Providence, Rhode Island. Attorney-at-law, Edwards and Angell, Providence, Rhode Island; Legal Counsel, Rhode Island Medical Society.*

MEMBERS OF THE MEDICAL PROFESSION pay a greater lifetime federal income tax than others of equivalent earning status because their period of high income potential tends to be bunched into a relatively short number of years. But this disadvantage is compounded by the fact that doctors — and other professional men — customarily practicing in partnership or sole proprietorship form are not accorded the further advantage, available to high-bracketed corporate officials, of having a percentage of their annual income contributed to a profit sharing or retirement plan and not taxed in the year earned.[1]

In an attempt to alleviate this inequality of tax treatment, a rash of state legislation has been passed, in the main during the past year and a half, allowing professional men to incorporate or to exist as "associations" taxable as corporations. To date 20 states have passed statutes designed to permit professionals to associate in such a way as to accord more favorable tax treatment. Similar legislation was introduced in the Rhode Island General Assembly in 1962 but was not reported out of committee although there was no discernible opposition; apparently, the pressure behind it was not great enough.

Why is the movement for corrective state legislation necessary when the problem is basically one of federal income tax law? The answer lies in the failure of Congress during the past decade to correct this inequality in taxing income of professional people. Provisions of the Internal Revenue Code permit the creation of qualified pension, annuity or deferred profit sharing plans for corporate employees, in which untaxed income is accumulated and invested free of tax pending distribution after retirement when individual surtax rates are lower.[2]

A "Corporation" in the Picture

To be accorded this favorable tax treatment there must be an employer in the picture qualifying as a corporation, defined to include "association,"[3] a nebulous entity that would stir the imagination of Lewis Carroll. Because of traditional methods of practice and ethical limitations on the corporate practice of medicine, doctors, generally, have been denied the privilege of deducting from their taxable income contributions to these pension plans, at least not without stirring up a controversy with the treasury as to their status as "associations."

Perennially since 1951, legislation has been introduced in Congress that would change the present law and permit self-employed persons, including doctors and professional men, to have deferred compensation plans within the framework provided for corporate plans. Variously called the Jenkins-Keough Bill and H.R. 10, until 1960 the measure was continuously opposed by the treasury on the grounds that the revenue loss would be staggering. The loss was estimated at $365 million per annum on a coverage of 7 million people; 26 million persons are now covered by qualified corporate plans.

On April 1, 1960, in a letter to Senator Harry Byrd, Chairman of the Senate Finance Committee, the treasury turned about-face and withdrew its objections to the bill if amendments were made to provide more adequate coverage for employees of the self-employed. The author of the treasury letter, Under Secretary Fred C. Scribner, Jr., recognized that the bill would "eliminate the problems now resulting from attempts by partnerships to secure classification as a corporation for tax purposes in order to be eligible for coverage in a qualified pension plan."[4]

Measure Fails in Senate

Although the bill passed the House and was reported favorably out of the Senate Finance Committee in 1960, the year of the treasury's about-face, the Senate failed to act on the measure before adjournment. Again in 1961, H.R. 10 was passed in the House but died on the Senate floor. Thus, after 10 years of frustration in Congress the self-employed, unincorporated taxpayers were back where they started, and in 1961 the move to bring this element within the unamended Internal Revenue Code was rekindled and the rush was on to provide for incorporation of professional men by state legislation. The treasury, however, still holds

continued on next page

the whip hand and at this time it is still doubtful whether or not this state legislation will give the doctors not only what they want but also the rights they once had.

Any statute providing for some entity, whether corporation or association, which would satisfy federal requirements for pension plans must of necessity entail a significant departure from traditional forms of medical practice. The A.M.A. has removed a long-standing policy against corporate medical practice by not opposing the new statutes so long as the ownership and control of the corporations are in the hands of doctors of medicine. However, the A.M.A. legal conference held in Chicago in May, 1962, concluded that doctors should not rush into a corporate form of practice until it is established definitely that the statute adopted in their state will provide the necessary tax and subsidiary advantages sought in view of the series of roadblocks interposed by the treasury.

History of Doctors' Pension Plans

In order to understand this Alice in Wonderland confusion, it is necessary to review, at the risk of over-simplification, the history of previous efforts of medical groups to qualify pension plans with federal tax authorities. Over the course of recent years a handful of doctors, usually associated as a clinic, have sought and obtained favorable tax treatment for pension plans by forming "associations," without the aid of state enabling acts. Recognition as corporate tax entities by these groups has been hard won, often as the result of litigation with the Internal Revenue Service.

Most celebrated of these court battles was the 1954 decision of the U.S. Court of Appeals for the Ninth Circuit in the *Kintner* case.[5] Doctor Arthur R. Kintner and seven other Montana physicians formed an association to operate a clinic, forming a pension trust and contending that they should be taxed as a corporation. The Court of Appeals agreed in essence and held that although one could not practice medicine in the corporate form in Montana, doctors could form an "association" for federal income tax purposes.

One would have expected doctors to have tripped over one another rushing to form "associations" after this decision, but the truth is that such an organization is never sure until they have obtained a ruling from the Internal Revenue Service ("IRS") and IRS has remained silent as to its position; an atmosphere of tax uncertainty is an effective weapon to the IRS, because as long as it exists tax planning is virtually impossible. Some associations have found themselves in the embarrassing position of adopting pension plans following the court decision in the Kintner case and now facing the possibility of having their contributions disallowed by IRS.

Regulations Define Associations

The silence was broken in November, 1960, by the publication of final treasury regulations regarding associations.[6] These provided that for a group of professionals to qualify for corporate tax treatment the association had to show more "corporate" than "non-corporate" features. In essence a majority of these characteristics, known in the aggregate as the Kintner regulations because they have in effect emasculated the Court decision in the Kintner litigation, must be present: 1) centralized management, 2) continuity of life, 3) limited liability, and 4) free transferability of interest. In the application of these regulations the IRS has shown a remarkable ability to prevent medical groups from enjoying tax benefits afforded others.

But with at least somewhat more definite standards enunciated, impetus was given to passage of the enabling state legislation designed to fit within these requirements. In 1961 alone fourteen states passed measures permitting either professional associations or corporations. And medical practitioners have been taking advantage of these statutes, but until IRS clarifies its own regulations they are risking the chance that the new associations will not qualify for corporate tax treatment.[7] At least one tax expert, Professor Boris Bittker of Yale Law School, who may well represent the IRS view, has expressed considerable doubt about the effectiveness of the legislation.[8]

Possible IRS Objections to New Laws

The characteristics the IRS finds objectionable in the associations or professional corporations may well drive doctors to despair but do not surprise the tax practitioner who is constantly facing these semantic and conceptual problems in dealing with IRS:

1. The characteristic of "limited liability"— i.e., limited to the corporation — might be violated by the attempt of the new statutes to preserve in various ways the traditional personal relationship between the doctor and his patient, his personal liability for malpractice and the tortious acts of associates and assistants. And yet ethical, if not legal, principles necessitate a continuation of protection of the patient along these lines.

2. Under the regulations, an organization has "centralized management" if some but not all of its members make the necessary management decisions. But if the IRS finds that the regulation requires the centralized management to make professional decisions, such an association in a particular case might become undesirable for the medical practitioner operating in a small association. However, actual experience, and Doctor Kintner's

organization is a good example, has shown that centralized management in the large professional corporation has worked out very well.

3. A corporation should have "continuity of life." A partnership is dissolved under the Uniform Partnership Act (adopted in many states, including Rhode Island) by the death or withdrawal of a partner. When a doctor-member of an IRS-qualified "association" dies, for instance, his share would pass to his heirs or legatees; because in this event an unqualified, nonmedical person would hold the doctor's interest, the association might be dissolved and "continuity of life" lost.

4. Professor Bittker takes the position that since most state laws provide for associations performing professional services only through persons licensed by the state in that profession, this restricts the free transferability of interest in the association.[9] Therefore, another corporate characteristic under the Kintner regulation might be in jeopardy.

More Corporate Than Not?

It should be stressed that the Kintner regulations only require that such associations have more corporate than non-corporate characteristics. Thus one of the above-noted objections could be present if the other three were not, and the association could still be accorded corporate tax status. But the treasury makes this decision in each particular case.

In addition to the uncertainty of the tax status of the new professional incorporation laws, doctors should be aware of other disadvantages to corporate or quasi-corporate practice. We have mentioned the undesirability of centralized management, at least in the case of a small professional corporation or association. If the group is formed as a corporation, there are formalities that must be attended to which doctors will now have to take the trouble to perform. Further, income earned by a group qualifying as a corporation may be subjected to a double tax, first at corporate rates and again on distribution at individual rates. Subject to close IRS scrutiny for reasonableness, some of this double taxation may be avoided by salaries paid to the "shareholder"-employees, deductible by the "corporation." Also, if the professional association is made up of ten or fewer members, it could elect to be taxed as a partnership. IRS will also be watching for unreasonable accumulations of undistributed earnings which, when found, subject the taxpayer to a penalty — a higher tax rate, of course.

The Rhode Island Statute

The bill introduced into the Rhode Island General Assembly was designed to meet the criteria of the Kintner regulations and permit incorporation of professional people under the regular business corporation statute. It was not reported out of committee. Unquestionably the measure will be re-examined and re-introduced next year, and for whatever good it might accomplish all professional people should exert pressure for its passage.

The bill contains some unique provisions which may overcome some of the objections mentioned above and which received favorable comment by the Legal Division of the A.M.A. Any corporation organized under the proposed act would be required to carry liability insurance for the tortious acts of *any* employee. This could possibly resolve the conflict between the treasury regulation requirement of limited liability and the traditional liability of the doctor not only for his own acts but also those of his associates and assistants.

Furthermore, by a well-developed scheme of preemptive rights, actually similar to those found in many other corporations, it is hoped that the Rhode Island legislation will overcome objections based on lack of free transferability of its stock interests and continuity of its existence. Interwoven into this section of the proposed act is a requirement that any shareholder or officer must be authorized to practice the profession being incorporated, maintaining at the same time the assurance that doctors, for instance, and only doctors, will control the medical corporation. Such exclusive "medical" control is a condition of A.M.A. approval of state legislation.

The Final Solution?

In summation there are two basic problems attached to the remedial state legislation permitting incorporation of medical practice: 1) from a federal tax standpoint the state legislation may not meet IRS interpretations of its own regulations; and IRS has not acted on about 90 applications presently pending for favorable tax rulings; and 2) other disadvantages are created for men practicing medicine which tend to minimize the attractiveness of deferred profit sharing or retirement plans.

It is possible, then, that the final solution to the problem lies in passage of federal legislation similar to that which has failed of passage in Congress for over a decade. True, the lack of affirmative action by Congress has been discouraging, and it is possible that H.R. 10 will be amended into ineffectiveness, but the experience gained by Congressional hearings and reports on the proposed measures has been vast, and the situation does, after all, center on the income tax, a matter of exclusive Federal concern. Furthermore, federal action would obviate the necessity of doctors practicing under a corporate or association "roof," something far afield from traditional modes of practice. For federal legislation, it is hoped, would permit the estab-

continued on page 413

AN ACT in Amendment of and in Addition to Title 7 of the General Laws, Entitled "Corporations, Associations and Partnerships," as Amended, and Authorizing Certain Business Corporations to Engage in the Practice of Rendering Professional Services.

The following legislative proposal was introduced in the Rhode Island General Assembly during its 1962 Session at the request of the Rhode Island Bar Association. It probably will be re-introduced in January, 1963, and as it is of significant interest to every physician the editors urge a careful reading of it in connection with the article by Mr. Charles P. Williamson on *Doctors, Incorporated* which appears in this issue.

It is enacted by the General Assembly as follows:

Section 1. Title 7 of the general laws, entitled "Corporations, associations and partnerships", as amended, is hereby further amended by adding thereto the following chapter:

"Chapter 5.1
"Professional Service Corporations

"7-5.1-1. Application of general corporation law.—Except as in this chapter otherwise provided, all provisions of the general corporation law applicable to domestic business corporations shall be applicable to corporations organized under this chapter.

"7-5.1-2. Definition of terms.—As used in this chapter:

'Professional services' shall mean the rendering of personal services by a person authorized to practice as one of the following professions as defined in the general laws: (1) physicians and surgeons; (2) dentists; (3) attorneys-at-law; (4) osteopaths; (5) professional engineers; (6) architects; (7) certified public accountants; (8) veterinarians; (9) chiropractors; (10) chiropodists; (11) registered nurses, or (12) optometrists.

'Regulatory agency' shall mean: (1) the division of professional regulation when referring to physicians and surgeons, dentists, osteopaths, chiropractors, chiropodists, registered nurses or optometrists; (2) the supreme court when referring to attorneys-at-law; (3) the board of registration of professional engineers when referring to professional engineers; (4) the board of examination and registration of architects when referring to architects; (5) the board of accountancy when referring to certified public accountants; (6) the board of veterinarians when referring to veterinarians.

'Authorized to practice' shall mean duly licensed, certified or registered by the proper regulatory agency.

"7-5.1-3. Authority to practice.—Any corporation organized under this chapter may engage in rendering professional services of only one of the professions enumerated in section 7-5.1-2, provided that every officer, director, and shareholder of said corporation is an individual authorized to practice such profession and is actively employed by the corporation in such practice. No such individual may be an officer, shareholder, director or employee of any other corporation engaged in the practice of the same profession.

"7-5.1-4. Investments.—Nothing herein contained shall be interpreted to prohibit any corporation organized under this chapter from investing its funds in real estate, mortgages, stocks, bonds, or any investment not otherwise prohibited by the general corporation law, or from owning real or personal property appropriate to the rendering of professional services.

"7-5.1-5. Eligibility of personnel—Transfer of stock.—If the articles of incorporation or the by-laws of the corporation restrict transfer of its shares, and transfer of such shares to an eligible person is thereby prevented, the corporation shall redeem the shares of the ineligible shareholder, and shall compensate such ineligible shareholder in full for the fair market value of his shares determined as of the date that the ineligibility occurred. Nothing herein contained shall be interpreted to prevent a shareholder and the corporation from making a binding agreement as to a method for determining such fair market value. In the event the corporation and an ineligible shareholder cannot agree as to the fair market value, the regulatory agency shall, upon application by either party, appoint a board of not less than three qualified persons engaged in performing similar professional services to determine the fair market value of such shares, and the decision of such board shall be final and binding upon the parties. The redemption of its shares by a professional service corporation shall not be effected at a time or in a manner so as to impair or prejudice the rights or remedies of any creditor of the corporation. As used in this chapter, 'ineligible shareholder' includes a shareholder electing to retire or withdraw from active employment in the

corporation. Nothing herein contained shall be interpreted to prohibit the temporary exercise of incidents of ownership of stock in any such corporation by persons or corporate fiduciaries not authorized to practice, solely for purposes of administering estates of shareholders deceased or under legal disability to transfer their shares. If any shareholder shall become ineligible, he shall transfer his shares to an eligible person, or offer them to the corporation for redemption at their fair market value.

"*7-5.1-6. Qualifications of employees.*—Every corporation organized under this chapter may render its professional services only through employees who are authorized to practice; provided, however, that nothing herein contained shall be interpreted to prohibit any such corporation from employing unlicensed persons to perform functions not constituting such professional services.

"*7-5.1-7. Names.*—The name of every professional service corporation shall end with the words 'corporation' or 'incorporated' or the abbreviations 'corp.' or 'inc.'; and such designation in the corporate name shall constitute notice to every person or corporation availing himself or itself of the services of any such corporation, that it is organized under the provisions of this chapter. Each regulatory agency may impose additional requirements as to the names of corporations organized to render professional services subject to its jurisdiction.

"*7-5.1-8. Insurance required.*—Every professional service corporation shall maintain insurance against any liability imposed by law upon the corporation or its employees arising out of the performance of professional services, including liability for claims brought about or contributed by the dishonest, fraudulent, criminal or malicious acts or omissions of any employee. Such insurance shall be maintained in a company lawfully authorized to write such insurance in this state and shall be, with respect to each claim, in the aggregate amount of fifty thousand dollars ($50,000) multiplied by the number of professional employees of the corporation as of the policy anniversary date; provided, however, that in no case shall the coverage be less than one hundred thousand dollars ($100,000) and not more than five hundred thousand dollars ($500,000) coverage shall be required of any such corporation.

"Every insurance company shall furnish to the incorporators of each corporation to be insured by it a certificate which shall recite that application for such insurance has been duly made and that a policy of insurance as required will be issued, the amount of coverage to be provided, and the expiration date of the policy. The incorporators shall file said certificate in the office of the secretary of state at the time of filing the original and a duplicate of the articles of association, and the secretary of state shall not certify the duplicate articles of association unless said certificate of insurance has been filed. Thereafter, every insurer shall notify the secretary of state and the insured of the termination of such insurance not more than thirty days nor less than ten days before the effective date of such termination. Upon receipt of such notice, the secretary of state shall inform the appropriate regulatory agency of such notice.

"*7-5.1-9. Privileged communications.*—Nothing contained in this chapter shall be interpreted as requiring disclosure by any employee of a corporation organized under this chapter, of any communication heretofore privileged from disclosure.

"*7-5.1-10. Powers of regulatory agency.*—Nothing contained in this chapter shall be interpreted to abolish, repeal, modify, restrict, or limit the powers of any state regulatory agency, to regulate the conduct of the professional services pursuant to law.

"*7-5.1-11. Severability.*—If any provision of this chapter or the application thereof to any person or under any circumstances shall be held invalid by any court of competent jurisdiction, such invalidity shall not affect any other provision or the application thereof, and it is hereby declared to be the legislative intent that this chapter and the provisions thereof would have been enacted if such invalid parts had not been included therein.

"*7-5.1-12. Short title.*—This chapter may be cited as the professional service corporation law."

Sec. 2. This act shall take effect upon its passage, and all acts and parts of acts inconsistent herewith are hereby repealed.

DOCTORS, INCORPORATED

continued from page 411

lishment of pension and profit-sharing trusts whether the doctors practiced as individuals or as partnerships.

The end result of the state incorporation and association legislation may be to embarrass the federal government into action. In a way, the statutes are a method of indirect lobbying.[10] The present situation unquestionably presents an inequity of tax treatment. Both the House Ways and Means Committee, the chief tax measure steering committee, and Stanley S. Surrey, current assistant treasury secretary in charge of tax policy, are advocates of equality of tax treatment. If they are sufficiently aroused by the rash of corrective state legislation, which varies in form in practically every state, and the more direct influence of all self-employed and professional men, it may be only a matter of time before the Internal Revenue Code is amended and the state statutes become nugatory.

concluded on next page

The moral of the story is, therefore, look before you leap into the corporate practice of medicine. Once in, it may be difficult and perhaps costly to liquidate. It's the treasury, no longer Providence, that shapes our ends.

Bibliography

Bittker, "Professional Associations and Federal Income Taxation," 17 *Tax L. Rev.* 1 (1961)

CCH, *New Professional Corporation Laws Explained* (1962)

House of Representatives of the United States, *H.R. 10, A Bill to Encourage the Establishment of Voluntary Pension Plans by Self-employed Individuals* (1961)

Internal Revenue Code of 1954, §§401-04, §7701 (a) (3)

Maier and Wild, "Taxation of Professional Firms as Corporations," *Marquette L. Rev.*, December, 1960

Rapp, "The Quest for Tax Equality for Private Pension Plans: A Short History of the Jenkins-Keough Bill," 14 *Tax L. Rev.* 55 (1959)

Rhode Island General Assembly, *An Act Authorizing Certain Business Corporations to Engage in the Practice of Rendering Professional Services to the Public* (1962)

Scribner, Fred C., Jr., "Treasury Letter to Senator Harry F. Byrd, Chairman, Senate Finance Committee," (1960)

Silberman, "Professional Men Push for Incorporation, Aim at Income Tax Savings," *The Wall Street Journal*, May 23, 1962

Treasury Regulations, §301.7701 — 1 & 2

---

[1]*Internal Revenue Code of 1954*, §§401-404.

[2]Tax-deferred retirement advantages are not the only benefits available to a doctor or other professional qualifying as an employee of a corporation, but because it is the most important advantage, it is the focal point of this article. Other advantages are: 1) premiums on group life and group medical policies paid by the corporation are deductible by the corporation; 2) medical care reimbursement by the corporation can be tax-free; and 3) employees can receive up to $100 a week tax-free during an illness or incapacity.

[3]*Internal Revenue Code of 1954*, §7701 (a) (3).

[4]Letter of Fred C. Scribner, Jr., Under Secretary of the Treasury, to Senator Harry F. Byrd, Chairman of the Senate Finance Committee, April 1, 1960.

[5]*Kintner* v. *United States*, 216 F 2d 418 (9th Cir., 1954).

[6]Treas. Reg. §301.7701 — 1-2 (1960).

[7]According to *The Wall Street Journal* some 90 new organizations have applied for IRS rulings on their corporate tax status. Silberman, "Professional Men Push for Incorporation, Aim at Income Tax Savings," *The Wall Street Journal*, May 23, 1962.

[8]Bittker, "Professional Associations and Federal Income Taxation," 17 Tax L. Rev. 1 (1961).

[9]Bittker, *supra*, pp. 17-21.

[10]There is an interesting analogy in income taxation history to the present situation regarding professional incorporation. In the years prior to 1948, many states, realizing the income tax advantages attendant upon the Spanish-originated community property system in the southwestern states, began to adopt similar legislation in order to attribute income earned by the husband to both husband and wife. The outburst of legislation in the states paved the way to passage in Congress of the Revenue Act of 1948 permitting joint income tax returns and marital deduction allowances for estate and gift tax purposes.

CONGENITAL MUSCULAR TORTICOLLIS

concluded from page 404

[4]Heusinger, cited by Lidge, Bechtol and Lambert

[5]Holloway, L. W.: Caput Obstipum Congenitum. So. Med. J., 24:597-601, 1931

[6]Jones, Sir Robert, and Lovett, Robert W.: Orthopedic Surgery, New York, William Wood and Company, 1924

[7]Kiesewetter, W. B.; Nelson, P. K.; Palladino, V. S., and Koop, C. E.: Neonatal Torticollis, J. Am. Med. Assn., 157:1281-1285, 1955

[8]Krogius, Ali: Zur Pathogenese des muskularen Schiefhalses. Acta Chir. Scandinavica, 56:497-512, 1924

[9]Lidge, Ralph T.; Bechtol, Robert C., and Lambert, Claude N.: Congenital Muscular Torticollis. J. Bone and Joint Surg., 39-A, No. 5: 1165-1182, October, 1957

[10]Middleton, D. S.: The Pathology of Congenital Torticollis. Brit. J. Surg., 18:188-204, 1930

[11]Mikulicz, J.: Uber die Exstirpation des Kopfnickers beim Muskularen Schiefhals, nebst Bernerkungen zur Pathologie dieses Keidens. Contralbl. f. Chir., 22:1-9, 1895

[12]Nove-Josserand and Viannay, Charles: Pathogenie du torticollis congenital (Theorie ischemique). Rev. d'Orthop., 7:397-425, 1906

[13]Parker, R. W.: In a discussion of the Relationship between Wryneck and Congenital Haematoma of the Sternomastoid at a meeting of the Royal Medical and Chirurgical Society, Lancet 1:247-1893

[14]Shellhamer, Robert: personal communication, 1961

[15]Stromeyer, G. F.: Beitrage Zur operationen orthopaedik, Hannover, Helwing, 1838

[16]Taylor, Frederick: Induration of the sterno-mastoid muscle. Trans. Path. Soc. London, 26:224-227, 1875

[17]Witzel, Oscar: Beitrage Zur Kenntniss der secundaren Veranderungen beim muscularen Schiefhalse. Deutsche. Zeitschr. F. Chir., 18:534-578, 1883

PREVENTION — A CHALLENGE TO THE MEDICAL PROFESSION

concluded from page 408

most helpful to you, we also welcome your proposals and suggestions.

I have asked far more questions than I have answered but I am confident that, as we think about these issues and exchange views on them, the patterns we seek will evolve. This conference itself is a most constructive step. I hope that the contacts all of us make here will result in continuing relationships which will be both pleasant and productive.

PATRONIZE

JOURNAL ADVERTISERS

Editorials

A BACKWARD STEP?

At the meeting of the Rhode Island Medical Society on May 9, of this year, a resolution was adopted which recommended to the House of Delegates that the editor-in-chief of this Journal be dismissed. The main reason for this recommendation appears to be that those of the Society who voted in favor of its adoption believe it to be wrong to suggest that hospitals should be encouraged to make sure, as far as possible, that the best trained surgical assistants who are available should be selected to assist in major surgical procedures. No one can doubt the importance of teamwork in surgery, or that surgical teams are most effective when both surgeon and assistant are well trained and used to working together. This is not to say that a label of membership in the College of Surgeons or Board certification necessarily indicates that a doctor is a more able assistant than one who does not wear these labels. It is undoubtedly true that a physician who is doing general practice may, with years of experience, have made himself a good assistant. It must be equally true that a man in general practice, not trained by years of teamwork with a particular surgeon and selected merely because he was the referring physician, is not likely to have the skill necessary to make him the best choice as assistant.

However that may be, it is not the question on which the House of Delegates will be called upon to act. The question is this: Whether or not when the distinguished and able scholar, under whose leadership the Journal has reached a point of excellence never surpassed in its history and who as editor-in-chief bears responsibility for an editorial in which certain of its statements are at variance with the opinion of a number of the members of the Rhode Island Medical Society he should be summarily dismissed. The columns of the Journal are always open to the discussion of controversial questions, discussions which can throw light on various aspects of such questions and allow the membership to form well-considered judgments. Must the editor and his board always refrain from expressing opinions on important topics until he has completed the usually impossible task of finding out what the majority of the members think, and then attempt to parrot that opinion? What kind of leadership is that? Where is freedom of speech under such circumstances?

Should not the editor of the Journal and his board freely express honest opinions on important subjects, thus stimulating discussion and a free exchange of ideas which can lead to an eventual determination of the sentiments of the membership of the society? Or, on the contrary, on the basis of a statement of disagreement with an editorial opinion embodied in a resolution and presented at a meeting of a small proportion of the membership who have had no opportunity to hear anything but the arguments on one side of the subject, should the editor be summarily dismissed?

In the opinion of the writer such a dismissal would represent a serious step backward for Rhode Island medicine. When one steps backward he should look carefully behind him lest he finds himself in a mess.

Alex M. Burgess, M.D., *Chairman*
Publications Committee

DOCTORS, INCORPORATED

In this issue an extremely interesting review of the considerations of corporate practice for the physician is presented by Mr. Charles P. Williamson, legal counsel of the Society. The review is one that we commend to all our readers, particularly in view of the fact that legislation to permit physicians, among others self-employed, to incorporate in Rhode Island has been introduced in the past two sessions of the General Assembly.

The legislation was first proposed locally two years ago by the Society, but it was not moved out of the legislative committee at the State House. This year a new version of the legislation, drafted by the Rhode Island Bar Association and approved

continued on next page

by its executive committee, was introduced, but in spite of the excellence of the proposed statute, and its commendable features for all persons self-employed, the Assembly adjourned without acting upon the bill.

This year, to our best knowledge, four states voted to authorize professional corporations or associations—Arizona, Kentucky, South Carolina, and Virginia, thus bringing to fifteen the number that have enacted the legislation. For more than a decade physicians have led the battle for what has been termed discriminatory tax treatment in the courts and legislatures of the nation. In business corporations no tax is paid while pension funds are being built. The individual recipient pays a tax on his pension money only when he receives it, but by then he is generally in a lower income bracket and his tax is therefore lower.

But in most states physicians and others self-employed cannot form corporations. Since the Congress has failed to act for years on the so-called Jenkins-Keogh legislation, the alternative has been to press for local laws in each state to make it possible for the self-employed to qualify for tax deferment that is currently available to major corporations.

Since it is anticipated that the Bar Association will again present its proposed statute to the General Assembly at its 1963 session, every physician should understand both the text of the bill (see page 412 in this issue) and all its implications.

MEDICAL ASPECTS OF SPORTS

THE SUCCESSFUL CONFERENCE staged by the Society's committee on athletic injury prevention a year ago has prompted the staging of a second conference, now scheduled for Monday, September 10, at the Carmichael Auditorium in the Psychology Laboratory building on the Brown University campus. The Conference, planned by the Society's committee on the *Medical Aspects of Sports*, will be for the athletic department personnel of the secondary schools of Rhode Island.

The current increased national interest in physical fitness has been reflected in stepped up activity in recent years by medical societies in assisting in educational programs to protect the health of the high school athlete. It is significant that the Rhode Island Medical Society has been one of the active leaders in this field with its fine conferences aimed at proper conditioning, careful coaching, the right equipment and facilities, and adequate medical care.

More than 125 school athletic officials participated in the Conference a year ago on the Providence College campus, and an equal number may be expected at the second meeting. But the Conference is one that should be of interest also to the physician in general medical practice who first sees many of these youngsters who are injured in athletic competition, and who also serves as the medical adviser to the local school teams engaged in competitive athletics. Hence the notice to all the membership of the program of the meeting for September 10 is not merely for information — it is equally intended as an invitation to physicians to join with the athletic directors, coaches, and trainers and thereby to learn of their concern for the welfare of young people, and their desire to have medical advice at all times.

PHOKOMELIA AND DRUG REGULATION

IN THE LAST TWO YEARS, a medical disaster has been reported from West Germany with the recognition of an epidemic of several thousands of cases of phokomelia. This little known disease of the newborn has in the past been recognized as a rare congenital abnormality — newborn infants with extreme shortening of the bones of the extremities producing markedly attenuated arms and legs that look like little flippers. In November, 1961, a drug, thalidomide, sold over the counter without prescription in West Germany as "contergan" and used as a sleeping medication, was incriminated as the cause of the tragedy. Pregnant women ingested this drug, often before knowledge of their pregnancy, and with great frequency later delivered babies with the alarming deformities of phokomelia. Thalidomide has been available elsewhere in Europe under various trade names, but its introduction into the United States was delayed two years by the Food and Drug Administration. No cases of phokomelia due to the drug are known in this country. Americans can only sigh with relief at the margin of their safety, then acknowledge the value of the watchdog role played by the government in regulating drug introductions.

The desirable extent of federal regulation of the American drug industry has been much in the news, underscored by lengthy hearings before the Senate Subcommittee on Antitrust and Monopoly. Drug prices have been called unreasonable and excessive. Lower prices to help poor people is an objective with strong emotional appeal. Documen-

tation of high profits comes from the National Industrial Conference Board which reports for 1961 that drug and medicine manufacturing had a profit margin of 19.7 per cent of net assets which was the highest profit of any of thirty-five manufacturing groups studied. A proposed remedy to lower drug prices is being considered by Congress in Bill S. 1552 which has proved a controversial measure.

Effective regulation depends as always on striking a delicate balance. This is a highly technical and difficult problem. The drug industry indeed has a case which has not always been as well publicized as that of the proponents of the bill; the industry has demonstrated rapid growth and has produced a fine variety of effective medicines, as any physician can testify. But extensive research programs and many research failures for each successful drug are costly undertakings and early obsolescence is an inherent risk. A successful drug has yielded good profits to the fortunate company. It is the prospect of these profits that spurs the search to the benefit of the people. Appropriate regulation, then, must not choke off the push toward an expanding horizon of medical therapy. One proposal, to reduce the duration of patent rights on drugs from seventeen to three years, seems an obviously stultifying road to cheaper drugs. The drug industry has not resisted government inspection, but it has challenged proposals to control its economic freedom and future potential. Clearly the government has served its people well in avoiding an epidemic of phokomelia in the United States. Here seems the proper place for effective government regulation.

GROSS UNPROFESSIONAL CONDUCT

At the recent session of the Rhode Island General Assembly the statutes were amended relating to refusal, revocation and suspension of professional certification for the healing art. The amended statute applying to physicians and surgeons now reads:

SECTION 1. Section 5-37-4 of the General Laws in Chapter 5-37 entitled "Physicians and Surgeons" is hereby amended to read as follows:

"5-37-4. *Refusal, revocation, or suspension of certificate.* — The division may, after due notice and hearing, in its discretion refuse to grant the certificate provided for in this chapter to any physician who is not of good moral character, or who has violated any of the laws of the state involving moral turpitude or affecting the ability of any physician to practice medicine, or who has been guilty of gross unprofessional conduct or conduct of a character likely to deceive or defraud the public, and may, after due notice and hearing, revoke or suspend any certificate issued or granted by it heretofore for like cause or for any fraud or deception committed in obtaining such certificate. Gross unprofessional conduct is defined as including but not being limited to

(a) The use of any false or fraudulent statement in any document connected with the practice of medicine.

(b) The obtaining of any fee by fraud or willful misrepresentation either to a patient or insurance plan.

(c) The willful violation of a privileged communication.

(d) Knowingly performing any act which in any way aids or assists an unlicensed person to practice medicine in violation of this act.

(e) The practice of medicine under a false or assumed name.

(f) The advertising for the practice of medicine in a deceptive or unethical manner.

(g) The obtaining of a fee as personal compensation or gain for an employer or for a person on a fraudulent representation that a manifestly incurable condition can be permanently cured.

(h) Habitual intoxication or addiction to the use of drugs.

(i) Willful or repeated violations of any of the rules or regulations of the State Department of Health.

(j) Gross incompetence in the practice of his profession.

(k) Repeated acts of immorality or repeated acts of gross misconduct in the practice of his profession.

(l) The procuring or aiding or abetting in procuring a criminal abortion.

Said division shall serve a copy of its decision or ruling upon any person whose certificate has been revoked or refused."

SEC. 2. This act shall take effect upon its passage.

E. P. ANTHONY, INC.
Druggists
WILBUR E. JOHNSTON, Phar. D.
RAYMOND E. JOHNSTON, B.S.
178 ANGELL STREET
PROVIDENCE, R. I.
GAspee 1-2512
Pharmacy License #225

WOMAN'S AUXILIARY TO THE RHODE ISLAND MEDICAL SOCIETY

ANNUAL REPORTS

1961 — 1962

Supplementary Report of President

IN MY REPORTS to the House of Delegates of the Rhode Island Medical Society; the National Historian, which will be printed in the "Minutes and Reports" issued by National this fall and my Annual Report delivered May 9th, I have given an over-all narrative picture of the Auxiliary accomplishments of the past year.

I have participated in the planning and programing of the WJAR-TV series *The World of Health* and in the radio program *The Rory Show*, WWON. Also the Society for the Prevention of Blindness, the Diabetic Detection Clinics, Family Day, Dinner Dance, 15th Anniversary celebration and the Exposition of Health Progress which were enjoyable and most successful.

It was my pleasure to attend the National Convention in New York City last June; the fall Conference for Presidents and Presidents-elect in Chicago; three meetings of the New York State Auxiliary at Rochester, Glen Falls and New York City; three meetings of the Massachusetts Auxiliary at Boston; one meeting of the Connecticut Auxiliary at Simsbury; one meeting of the Maine Auxiliary at Poland Spring and our own Kent County and Woonsocket Auxiliary fall meetings. I profited greatly in new ideas and information of value to our Rhode Island Auxiliary by attending these meetings.

I have presided over five Board meetings and two regular meetings, attended four finance meetings and innumerable committee meetings.

In an effort to expedite efficient operation of the Auxiliary business we established a financial voucher and secretarial filing systems and had the scrapbooks bound for posterity. The constitution and by-laws have been updated and a new printing issued; a necrology file established; a book of policies listed for easy reference and a complete new roster established.

It has been an interesting year and I am proud to have been president of the Woman's Auxiliary to the Rhode Island Medical Society.

Recommendations

1. A greater effort be exerted to make our one fund raising activity more productive financially.

2. A more stringent rule be effected whereby all expenditures shall be the responsibility of the individual unless they bear the written approval of the finance chairman.

3. A school of instruction be conducted in the early fall to provide a training program for county auxiliary officers and chairmen of committees.

4. Closer affiliation between state chairmen and component auxiliaries.

5. Have the minutes bound in a permanent record. Collect and bind all issues of the *Newsletter*.

6. Publish a summer issue of the *Newsletter* to introduce officers and members of the Board, and include a more detailed and meaningful report of the A.M.A. Convention at a time when component auxiliaries can benefit by it.

MRS. JAMES P. O'BRIEN

Annual Report of the Vice-President

The past year has been a very busy and interesting one for me. As vice-president I have attended board of directors and finance committee meetings, meetings of the Rhode Island Council of Community Services, Inc., and the planning meetings for the television series, sponsored by the Auxiliary, and shown on WJAR-TV.

On November 15th a diabetic fair was held at St. Joseph's Hospital. As usual, the vice-president was responsible for obtaining volunteers from the Auxiliary to work on this project. The support given this effort was most gratifying.

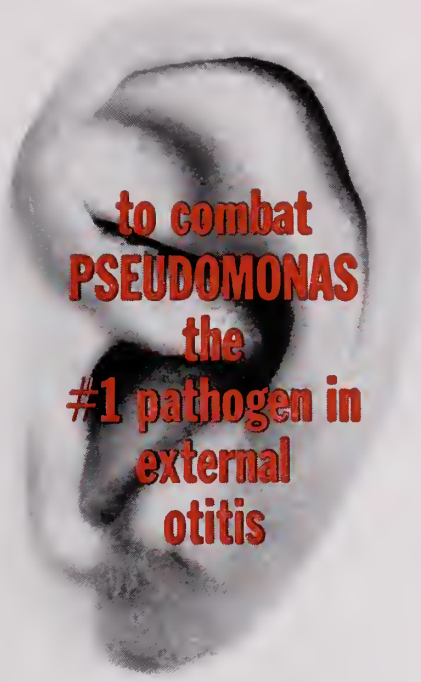
At the Rhode Island Medical Society Exposition of Health Progress I was one of the many volunteers who conducted tours for the schoolchildren of the state.

At the Annual Meeting, held on May 9th, the vice-president was the toastmistress at the luncheon, thereby relieving the president of this added responsibility.

During the year I read the minutes of all of the board and membership meetings, and have compiled the policies and resolutions of the organization. This I hope, will prove a ready reference for future officers of the Auxiliary.

MRS. LESTER L. VARGAS

continued on page 420



'CORTISPORIN'®

OTIC DROPS (sterile)

brand

the #1 therapy for inflamed, infected ears

Because it provides Polymyxin B for the eradication of Pseudomonas, the prime cause of external otitis, 'Cortisporin' is the logical choice of treatment for inflamed, infected ears. Polymyxin B is the antibiotic specific for *Pseudomonas aeruginosa* infections, and is, for this pathogen, the standard of effectiveness against which other antibacterials are measured.

- Anti-inflammatory
- Antipruritic
- Antibacterial



Each cc. contains:

'Aerosporin'® brand Polymyxin B sulfate	10,000 units
Neomycin Sulfate (Equivalent to 3.5 mg. Neomycin Base)	5 mg.
Hydrocortisone	10 mg. (1%)

Bottles of 5 cc. with sterile dropper.

Literature available on request.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

WOMAN'S AUXILIARY

continued from page 418

Report of the Recording Secretary

There have been three membership meetings during the past year.

The fall meeting was a joint endeavor with the Rhode Island Medical Society in the form of a Family Day. The date was Sunday, October 15, 1961 at the Anderson Farm in Coventry, Rhode Island.

The midwinter meeting, the 15th Anniversary of the founding of the Auxiliary, was held on February 6, 1962 at Wannamoisett Country Club. Mrs. Angelo Archetto read a summary, compiled by Mrs. J. Murray Beardsley, of the highlights of each of the presidents during her term in office. The four speakers of the afternoon were representatives from the Industrial National Bank and the Rhode Island Hospital Trust who discussed the *Investment Program for Physicians.*

The 16th Annual Luncheon is being held today, May 9, 1962, at the Garden Restaurant of the Biltmore Hotel in Providence.

During the year there was one Executive Board meeting and six joint meetings of the Executive Board and Committee chairmen.

Minutes of all meetings, reports and communications have been duly recorded and filed.

MRS. EDWARD DAMARJIAN

Report of the Corresponding Secretary

The duties of the corresponding secretary's report for 1961-1962 have consisted mainly of sending out Board notices, invitations to presidents and presidents-elect of Eastern regional to our various luncheons and functions. Cards of sympathy have been sent to families of deceased medical members. I have attended many meetings such as Family Service Welfare, Legislation at the State House, and Mental Health Group — all of these notes and correspondence will be found in my file. Any and all of the essential correspondence which our president, Mrs. O'Brien, has seen fit for me to complete, I have done so. Letters were recently sent out to pharmaceutical companies and others who were kind enough to donate to our Health Fair. Also letters of thank you were sent to Auxiliary members who gave so willingly and free of their time to the Health Fair. During the year I have sent letters to Doctor Adelson and Mr. John E. Farrell on an official basis and only when the Board so noted that I do so. Many letters of acceptance and thank yous, also letters on an official level

1 2 3 4
clinical studies repeat...

ARLIDIN IMPROVES HEARING[1]
ARLIDIN IMPROVES HEARING[2]
ARLIDIN IMPROVES HEARING[3]
ARLIDIN IMPROVES HEARING[4]

Arlidin is available in 6 mg. scored tablets, and 5 mg. per cc. parenteral solution.
See PDR for packaging.
Protected by U.S. Patent Numbers: 2,661,372 and 2,661,373.

1 "significant hearing improvement" occurred with Arlidin in 32 of 75 patients with recent onset hearing impairment due to labyrinthine artery ischemia.
Rubin, W. and Anderson, J. R.: Angiology 9:256, 1958.

3 Arlidin "appears to be one of the most satisfactory [vasodilators], having the advantages of minimal side effects, being well tolerated and possessing a sustained action" in improving circulation of the inner ear.
Seymour, J. C.: Laryngology & Otology 74:133, 1960.

which I have received are all placed in file. At this time of year we are getting ready for our annual luncheon and installation of officers on May 9, 1962, Sheraton-Biltmore. Invitations have been sent out to all invited guests, and many have responded favorably. My complete file of correspondence for the Woman's Auxiliary to the Rhode Island Medical Society will be placed in the Medical Library.

MRS. NATHANIEL D. ROBINSON

Report of the Historian

With the approval of your president and the Board, the two scrapbooks which were found to be in a sad state of disrepair have been completely reassembled and bound in new red buckram covers with gold lettering. A third volume large enough to contain historical data for several years was also prepared. News items for the current year will be ready for your inspection at the annual meeting.

Acknowledgment and thanks is offered Mrs. John J. Cunningham who lettered with much skill the pages for the new volume for the current term.

The librarian of the Rhode Island Medical Society has invited us to place these three volumes in one of the bookcases in the main reading room where they will be easily accessible at all times.

MRS. J. MURRAY BEARDSLEY

Kent County Auxiliary Report

The Kent County Medical Auxiliary has grown from a charter membership of twenty in 1954 to a group of seventy in 1962. We have actively supported all functions of the Woman's Auxiliary of the Rhode Island Medical Society with several of our members in key positions on the state level.

Meetings were held in October, January and April. The October meeting was a "favorite recipe" luncheon held at the home of one of our members. We feel this was one of our more successful meetings. A splendid variety of delicious foods prepared by our members was offered. Each member brought a specialty dish. Recipes were collected and a cookbook is planned in the future.

It has become, more or less, a custom for the Kent County Medical Auxiliary to hold a post-yuletide auction at the January meeting where some $50 is added to our treasury.

Since 1962 is an election year for the Kent County Medical Auxiliary, the following new officers were seated at the April meeting:

President ..... MRS. DONALD O'HANIAN
Vice-President ..... MRS. CARL ANDERSON
Secretary ..... MRS. GILBERT HOUSTON
Treasurer ..... MRS. THOMAS GEORGE

continued on next page

2

vascular insufficiency of the labyrinth is an important etiologic factor in sudden perceptive deafness . . . "vasodilators [Arlidin] are of considerable value."

Wilmot, T. J. and Seymour, J. C.: Lancet 1:1098, 1960.

4

early cases of sudden perceptive deafness should be treated by immediate stellate block "supplemented by the most effective vasodilator drug [Arlidin] . . . energetic measures to retain blood supply to the inner ear are imperative."

Wilmot, T. J.: J. Laryngology & Otology 73:466, 1959.

in impaired hearing, tinnitus, vertigo . . .

when due to ischemia of the inner ear . . .

arlidin®

brand of nylidrin hydrochloride N.N.D.

Clinical benefit in approximately 50% of cases of recent onset hearing loss treated with adequate vasodilator and other supportive therapy is also reported by Sheehy.

Sheehy, J. L.: Laryngoscope 70:885, 1960.

CAUTION: Like any effective peripheral vasodilator, Arlidin should be used with caution in the presence of recent myocardial lesions, severe angina pectoris and thyrotoxicosis. There are no known contraindications to its use. Complete detailed literature available to physicians.

u. s. vitamin & pharmaceutical corporation

Arlington-Funk Labs., div. • 800 Second Ave., New York 17, N. Y.

In view of our growing membership, addressograph plates have been obtained for each member. The Kent County Hospital Auxiliary has generously offered the use of its addressograph machine and provided us with storage space for the plates in its office at the hospital.

The American Medical Education Fund has been enriched by our policy of contributing $1.00 per capita. In May of 1961 we received a certificate of recognition for contributing more than any other auxiliary in the state to this fund.

Excellent rapport has been maintained with our sponsoring group, the Kent County Medical Society. We feel that we may have had some small share in preventing certain legislation, opposed by the Medical Society, from becoming law this spring.

Mrs. Richard R. Dyer, *President*

Newport Auxiliary Report

The Newport County Medical Society Auxiliary is one year old this month. Some of our activities for the past year have been:

1. Attending a Medical Society meeting with our husbands having the navy doctors and their wives as guests.
2. Several members helped with the Diabetic Fair held at the Newport Hospital.
3. Participated as guides to the schoolchildren at the Sesquicentennial Exposition of Health Progress.
4. Full assistance to the annual Nurses' Scholarship Bridge, sponsored by the Newport Hospital Woman's Auxiliary.
5. A.M.E.F. playing cards have been bought by all our members and a $50.00 contribution has been given to the A.M.E.F. scholarship fund.
6. Plans are being made for more educational and social activities in the coming year.

Mrs. Alfred M. Tartaglino, *President*

Pawtucket Medical Auxiliary Report

During this, our third year, our aim has been to try to get to know one another of the medical community a little better. The Pawtucket County group's activities therefore were mostly slanted to things "medical."

At our October luncheon meeting, very well attended, we "learned." The program about Civil Defense, presented by the city defense director and our own state chairman, was well received and proved most instructive.

Pawtucket's pre-auxiliary dance party in November aided the "getting-to-know-you" project to the enjoyment of all attending.

In March, at the winter luncheon meeting, the local auxiliary "did" for the medical cause by having a Dutch auction which benefited A.M.E.F. Also, at this meeting, we listened to the record *Operation Coffee Cup* and with the discussion following we "learned" of current medical legislation.

Later in March, this Auxiliary was pleased to help the men of the Pawtucket Medical Association in preparation for their annual Ladies' Night. It proved to be a most successful evening out and we like to feel that some of our efforts helped assure the fine attendance.

An informal evening get-together with our doctor husbands has been planned for June 27th at the Pawtucket Country Club.

The annual meeting and installation of officers is set for June 12th at the home of Doctor and Mrs. Robert Reimer in Barrington.

Mrs. John J. Cunningham, *President*

Woonsocket District Auxiliary Report

The Woman's Auxiliary to the Woonsocket District Medical Society held three meetings during the year, each being held on the last Tuesday of October, January, and April. Each meeting was preceded by a board meeting at the home of the president.

The membership increased to 39 with the admission of two new members and the return of another who had been absent from the state a few years. The average attendance at meetings was 20 members, or 50%, and membership dues are paid 100%.

The fall meeting took place at the Uxbridge Inn. Following the luncheon and business meeting Mrs. Elvi Archetto, president-elect, addressed us with a most interesting and informative talk on the national meeting which she had attended with Mrs. O'Brien, our president, in Chicago. The record by Ronald Reagan on socialized medicine was played and discussed.

Because of the possibility of inclement weather, which incidentally this year we had, the winter meeting took place at the home of the president as a dessert-coffee hour, business meeting, and travelogue film by Pan American titled *Tour of France*. It was voted to send $25.00 to A.M.E.F.

The Lafayette House was the setting for our spring and final meeting. After the luncheon and business meeting Miss Mabel E. Cooney, chief intake supervisor of the Family Court, spoke briefly on its establishment, function, and use in our state. It was noteworthy to learn that Rhode Island was the first state to establish a Family Court.

Since the organization of the Auxiliary in Woonsocket many social gatherings have been sponsored and enjoyed by its members and the doctors. This year a most successful cocktail and dinner party was held at the Pleasant Valley Country Club in December. Dancing and group singing completed the evening's entertainment.

As we close another year many thanks go to all the members for their constant support and cooperation in all activities.

Mrs. Euclid L. Tremblay, *President*

continued on page 424



Emotional control regained...a family restored... thanks to a doctor and 'Thorazine'

During the past seven years, 'Thorazine' has become the treatment of choice for moderate to severe mental and emotional disturbances because it is:

- specific enough to relieve underlying fear and apprehension
- profound enough to control hyperactivity and excitement
- flexible enough so that in severe cases dosage may be raised to two or three times the recommended starting level

Experience in over 14,000,000 Americans confirms the fact that, in most patients, the potential benefits of 'Thorazine' far outweigh its possible undesirable effects.

Of special value in mental and emotional disturbances: Tablets for initial therapy; Injection (Ampuls and Vials) for prompt control; Spansule® sustained release capsules for all-day or all-night therapy with a single oral dose.

Smith Kline & French Laboratories SK&F

Thorazine®

brand of chlorpromazine

A fundamental drug
in both office and hospital practice

For prescribing information, please see PDR or SK&F literature.

Posed by professional models.

WOMAN'S AUXILIARY

continued from page 422

A.M.E.F. Committee

The four organized component auxiliaries of the Woman's Auxiliary to the Rhode Island Medical Society have each conducted one "fun fund raising" event for A.M.E.F. in the form of luncheons, auctions and coffee hours. Playing cards and Christmas cards were sold and memorial sympathy cards used plus a few donations. The sums realized are not great, still an effort is being made.

MRS. JOSEPH C. KENT, *Chairman*

Auxiliary Bulletin

Until the outstanding change that has come to the Bulletin I cannot say that I have done much to promote subscriptions except to the members of the Executive Board and Committee Chairmen who subscribe 100%.

Now, with the new format, we shall try to make the members aware of the many helps to auxiliary work and above all, to the many services a doctor's wife can perform for her community.

MRS. PHILIP J. MORRISON, *Chairman*

By-laws Committee

On June 20, 1961, the following members of the Woman's Auxiliary to the Rhode Island Medical Society met at the home of Mrs. Thomas Head to discuss by-laws revisions: Mrs. James P. O'Brien, Mrs. Herbert E. Harris, Mrs. Joseph C. Johnston, Mrs. Lester L. Vargas, Mrs. Angelo Archetto and Mrs. Thomas Head. This committee suggested revisions and rewording of the constitution and by-laws. These were published in the winter *Newsletter*, and read at the February 6, 1962 luncheon to all the members in attendance. Vote was cast at this general meeting to accept all revisions as read. The constitution and by-laws, revised, were assembled and printed in pamphlet form in the spring of 1962. Available to all members now.

MRS. THOMAS HEAD, *Chairman*

Civil Defense

The CD Committee participated in a fall of 1961 and spring of 1962 TV program on medical self-help.

The Pawtucket auxiliary featured a CD lecture and exhibit at its fall 1961 luncheon meeting.

500 pamphlets on *What to Know about Fallout* and *Fallout Shelters* were mailed to all Auxiliary members.

The Auxiliary and the Rhode Island Medical Society are planning a joint program on training in medical self-help.

MRS. RAUL NODARSE, *Chairman*

Community Service Committee

As a public service feature the Woman's Auxiliary to the Rhode Island Medical Society sponsored a series of six television shows of community concern in co-operation with Station WJAR-TV on *The World Around Us* program. Important and interesting information was presented on Medical Quackery and Fads, Prevention of Blindness, Health in the Winter, Problems of the Aging, Plastic Surgery and Medical Civil Defense. Members of the Auxiliary and physicians participated. Valuable booklets were offered free by the medical Auxiliary on four of the shows.

On November 6, 1941, the Auxiliary was accepted as a member in the Rhode Island Council of Community Services, Inc. The Rhode Island Medical Society suggested our membership for public relations and so that we could combine our efforts in the field of community service.

In October we attended a three-day annual meeting conducted by the Rhode Island Conference of Social Work. A group of experts in various fields of social work led all-day discussions. There were ten such institutes.

All our efforts are currently being used to help with the Exposition of Health Progress. The Exposition is being presented by the Rhode Island Medical Society which this year celebrates its 150th year of medical progress in Rhode Island. More than seventy exhibits will be on display. It is the



Health Havens
100 WAMPANOAG TRAIL
EAST PROVIDENCE, R. I.
438-4275

A Truly Modern, Intermediate Care Facility Providing the Ultimate in Nursing Home Care at Reasonable Rates

Prepared to accept and adequately care for many acute cases as well as the more general convalescent and nursing home patients. We are limited to adults.

Our Nursing Administrator, Mary E. Baxter, R.N., will be pleased to discuss patient care with you.

first such health fair to be held in New England. The eighth grades of the state schools have been invited to view the exhibits. The Auxiliary has been asked to plan the tours and guide the groups through chosen exhibits.

The Society for the Prevention of Blindness, which we sponsored in Rhode Island this past year, requested us to set up a program of preschool vision screening. We were unable to undertake the project since it was decided that it was beyond our capabilities at this time.

Station WJAR-TV has asked us to arrange additional television programs this spring. We are preparing four shows to be seen in May. The subjects are: *A Recapitulation of the Exposition*, using film taken during the exhibit; *Medical Self-help; Poisons; Water Safety*. Members of the Auxiliary and physicians will participate. It has also been suggested by WJAR-TV that we plan a television series for the fall. It appears that our TV efforts will become a regular part of community service.

MRS. GEORGE A. ERNST, *Chairman*

Health Careers Committee

The Health Careers team of speakers gave an informal presentation at Woonsocket High School on November 27, 1961. A large group of students called "Mates in Medicine" were an intensely interested audience. Many asked questions and joined in the last-minute dash for the pamphlets which we try to keep available on each career represented.

Mrs. Francis McNelis and Mrs. Russell P. Hager represented Health Careers in the fall TV and radio programs.

It is always with real satisfaction that we award our annual scholarships and realize that the proceeds of the Dinner Dance are put to an effective use in aid to students who have almost "arrived" at their chosen careers. We have just given $300.00 to Miss Doris Hedstrom and $300.00 to Mr. Paul Oberg. Both students will be seniors next fall at the University of Connecticut, School of Physical Therapy. They were highly recommended by faculty representatives.

Many thanks to the faithful members of the panel who really recruit in earnest at each presentation to high school students: Mrs. Francis L. McNelis, dietitian; Mrs. Michael E. Scala, occupational therapist; Mrs. Charles W. Does, medical technologist; Mrs. Russell P. Hager, medical social worker.

MRS. HERBERT F. HAGER, *Chairman*

Hospitality Committee

Our first "Family Day" was held at Coventry Pines on October 15, 1961.

Hospitality, Program and many other Auxiliary members worked with the Rhode Island Medical Society on this affair.

Candy, apples and other treats were provided for the children and many prizes were awarded for various games and contests. Scheduled out-of-doors events were curtailed somewhat by the inclement weather, although a few hardy souls played golf, fished and joined in various sports. Later, a delicious barbecued chicken dinner was served. Despite one of the most uncomfortable days of the year, all who came seemed to enjoy it thoroughly and many expressed the hope that it would become an annual event.

The Annual Dinner Dance on November 11, 1961, was held at the Sheraton-Biltmore. Hospitality and Program helped the committee by soliciting and raffling liquor which added materially to our fund for community service projects.

Our 15th Anniversary was celebrated at Wannamoisett Country Club on February 6, 1962.

A decorated birthday cake, flower tapers and a pyramid of pastel iced tea cakes added to the décor.

Wannamoisett provided pretty pink table cloths and candles to complete the gay party theme.

For the annual meeting May 9, 1962, at the Garden Room a maypole theme was planned. Each table had a maypole centerpiece with streamers and a variety of pastel-hued tablecloths added to the gaiety of the occasion.

continued on next page



It has been such fun to serve the Auxiliary and to work with its members.

My grateful thanks to you all (particularly my committee) for your help and enthusiastic support.

MRS. RICHARD E. HAVERLY, *Chairman*

Legislative Committee

Here in Rhode Island we are in the unique position of being almost a city-state: it puts us on top of our problems and deprives us of seeing things in perspective.

As far as the King-Anderson bill is concerned, we have written letters to our two senators and our two representatives opposing the bill and stating our views, but frankly it was merely a formality; our congressmen are solidly behind the bill (you must remember the original Forand bill was introduced by a former Rhode Island representative), and are most unlikely to be swayed. According to the Executive Secretary of the Rhode Island Medical Society, the very most we could even hope of Rep. Fogarty, a good friend of medicine's, and Sen. Pastore, would be that they refrain from voting.

The Medical Society has spent a tremendous amount of time this year answering charges of abuse leveled at Physicians Service by officials of the Labor Movement here in Rhode Island. We in the Auxiliary have offered our time for lobbying or any other time-consuming activities that participating in legislation requires but we have not been called upon. A marvelous public-relations job was just accomplished by a fine Health Exposition which was sponsored by the Medical Society with a big assist from the Auxiliary. It was extremely well received and highly commended but what effect it will have on adverse legislation is anyone's guess.

The Rhode Island Medical Society neither refused us permission nor encouraged us to have the WHAM program. Although I personally considered their material far superior to "Operation Coffee Cup" (which has been used at meetings by both the Woonsocket and the Pawtucket auxiliaries), Mrs. O'Brien and I both felt that again we would end up talking to ourselves — i.e., to those who are already convinced. If this program could be presented say to nonmedical wives who are probably opposed to such legislation but have had neither the facts nor the inclination to dispute it, far more could be accomplished.

MRS. ARTHUR B. KERN, *Chairman*

Membership Committee

While acting as chairman of membership, my committee and I revised the roster to update it and to include telephone numbers.

Prospective new members were contacted by telephone and invited to join W.A.I.M.S.

Address plates were made for twelve new members by sending addresses to the Addressograph-Multigraph Corp. at 965 Waterman Avenue, East Providence, Rhode Island.

Address plates were also made for twenty-nine changes of address.

The files have been kept up to date.

There have been three resignations and three deaths.

One member has moved out of the territory.

Names of new members and names of those who have died or resigned are being listed to be attached to the roster.

MRS. DANIEL D. YOUNG, *Chairman*

Mental Health Committee

Our main tour this year was to the Ladd School, an institution for the mentally retarded child. This is the most neglected field in mental health and the most unrewarding and frustrating. The Auxiliary benefited greatly by being exposed to the handicaps of the mentally subnormal child, a field of which there is little awareness.

We continue to expand on our volunteer facilities to the various psychiatric institutes by providing physical care, entertainment and material comforts. We continued our close relationship with the other community services in psychiatry, *both* lay and professional.

The Auxiliary members have proven to be the best source of volunteer service.

MRS. PATRICK F. O'MAHONY

Program Committee

In an effort to promote attendance on the local level and to increase membership, this past year our county auxiliary program chairmen were encouraged to arrange for their meetings such programs as they believed would best accomplish this aim.

Each organized county group held three meetings and in addition, attended the three meetings scheduled on the state level.

For the first time in the 150-year history of the Rhode Island Medical Society, a program was planned last October to include the Medical Society, the Auxiliary and all members of their families. This was known as Family Day, and while strictly a social event it did gather together the entire family group. Family Day proved so popular and successful that it is now planned to make it an annual affair.

Each county group, together with the membership at large contributed to the state effort by participation in state sponsored community service projects, i.e., the Health Career Program; a TV

continued on page 428

asthma attack averted
. . . in minutes

patient protected
. . . for hours





Nephenalin®

(the dual-action anti-asthmatic tablet)

. . . works with nebulizer speed—provides four-hour protection

One NEPHENALIN tablet provides: *air in a hurry*—through sublingual isoproterenol HCl, 10 mg. *air for hours*—through theophylline, 2 gr.; ephedrine, ⅜ gr.; phenobarbital, ⅛ gr.

Dosage: Hold one NEPHENALIN tablet under the tongue for five minutes to abort the asthmatic attack promptly. Then swallow the tablet core for four full hours' protection against further attack. Only one tablet should be taken every four hours. No more than five tablets in 24 hours.

Supplied: Bottles of 50 tablets. For children: NEPHENALIN Pediatric, bottles of 50 tablets.

Caution: Do not administer NEPHENALIN with epinephrine. The two medications may be alternated at 4-hour intervals. NEPHENALIN should be administered with caution to patients with hyperthyroidism, acute coronary disease, cardiac asthma, limited cardiac reserve, acute myocardial damage, and to those hypersensitive to sympathomimetic amines. Phenobarbital may be habit forming. THOS. LEEMING & CO., INC., New York 17, N.Y.

WOMAN'S AUXILIARY

concluded from page 426

series, *The World of Health*; assisted the sponsoring Rhode Island Medical Society in making note of its Sesquicentennial year, specifically by supplying the man (women) power for guided tours of its Exposition of Health. This a week-long affair with tours for 11,300 Rhode Island schoolchildren!

The organized counties continued their excellent support of A.M.E.F., each in its own way raising funds for this very worthwhile endeavor.

The Program Committee, working closely with the Hospitality Committee, assisted in the three major state meetings of the year.

The increase in membership in each of the suburban counties has been most gratifying for while Rhode Island may be the smallest state in the U.S.A. in area, its medical auxiliaries are certainly large in enthusiasm and well endowed with hard-working civic-minded women.

MRS. CARL V. ANDERSON, *Chairman*

Publications Committee

The *Newsletter* of the Woman's Auxiliary to the Rhode Island Medical Society was published in October 1961, February 1962 and in April 1962.

The president, president-elect, all committee chairmen and county auxiliaries provided material for the *Newsletter*, and were most co-operative in sending their reports to the editor in time to meet the deadline dates.

It was necessary to ask that reports for publications be under 200 words, because of lack of space. It was suggested that the size of the *Newsletter* be increased, in order to allow more complete coverage of the activities of the Auxiliary.

MRS. BRUCE W. SMITH, *Editor*

Publicity Committee

The Woman's Auxiliary to the Rhode Island Medical Society received publicity during 1961-1962 in the newspaper and radio mediums.

The annual meeting and installation of officers, Family Day and the Fifteenth Birthday Anniversary Celebration received excellent coverage in both the printed word and pictures by the *Woonsocket Call*, hometown newspaper of Mrs. James P. O'Brien, president.

September 19, 1961, radio station WWON conducted a thirty-minute interview with four Auxiliary members covering some of the projects of the Auxiliary.

The annual dinner-dance for the benefit of the Scholarship Fund received publicity in the *Providence Sunday Journal* in the form of an article announcing the affair, followed by an explanatory picture in the *Providence Journal* on November 13, 1961.

We also received publicity on the community bulletin boards, announced on radio stations WPRO, WEAN, WJAR, WHIM, WICE and WWON. Posters were also displayed in all the hospitals in Rhode Island.

A television series, *The World of Health*, presented November 28 through January 9, was listed weekly in the television section of the *Providence Journal*. The Rhode Island Medical Society mailed fliers announcing the series to all its members and underwrote the cost of newspaper advertising in all six leading papers throughout the state.

Publicity for the Fifteenth Anniversary Celebration of the Auxiliary held February 6th, was printed in the Club Calendar of the *Providence Journal*.

Arrangements have been made for an announcement of the annual luncheon meeting to be held May 9, 1962, to be printed in the *Providence Sunday Journal* on May 6th, followed on May 10th by the second of two pictures allowed us by the newspaper per year. An article about Mrs. Angelo Archetto, along with a picture, will be printed in the *Cranston Mirror*, and will announce her installation as the new president of the Auxiliary.

Notice of the annual meeting will also be announced on the community bulletin board of station WPRO, the week preceding.



Fuller

Memorial Sanitarium

Located on Rt. 1

South Attleboro, Massachusetts

A modern non-profit hospital for the care and treatment of nervous and emotional disorders as well as long term geriatric problems.

Physical, neurological, psychiatric and psychological examinations.

Modern recognized psychiatric therapies.

A pleasant homelike atmosphere in a beautiful and conveniently located institution.

L. A. Senseman, M.D., F.A.P.A., Medical Director
Edwin Dunlop, M.D. Michael G. Touloumtzis, M.A.
Oliver S. Lindberg, M.D. William H. Dunn, M.S.W.
W. H. Lesovsky, M.D., Ph.D.

Referred patients are seen daily (except Saturdays) 9-12 A.M., and by appointment.
R. I. Blue Cross Benefits Tel. Southgate 1-8500

Special Rates for Long-Term Care

Carbon copies of all material submitted to the newspapers and the radio stations, along with the newspaper clippings, are on file in the publicity folder.

Listings of the various news media in the state, along with instructions of forms and deadlines, have been compiled and filed in the publicity folder.

MRS. IRA H. ANJOORIAN, *Publicity Chairman*

Safety Committee

The Woman's Auxiliary to the Rhode Island Medical Society was represented at the five training seminars held for the Conference of Women's and Parents' Organizations for Traffic Safety by the Rhode Island Council on Highway Safety. The purpose of these seminars was to develop an informed citizenry, acquainted with the problems and possible solutions of traffic safety. (This was the first group to participate in these seminars which are to be rescheduled later for other interested groups.) The topics were: 1. Enforcing for Traffic Safety — State Police Headquarters in Scituate; (Mrs. Raul Nodarse reported this meeting as I was unable to attend.) 2. Engineering for Traffic Safety — Traffic Engineering Department, Providence; 3. Educating for Traffic Safety — Rhode Island College; 4. Organizing for Traffic Safety — Roger Williams Building, and 5. Organizing for Traffic Safety — Firemen's Mutual Insurance Company.

I also attended the all-day Governor's Conference on Traffic Safety at the Sheraton-Biltmore on December 5, 1961.

These meetings were all most interesting and informative but have been fully covered at the Board meetings and in the *Newsletter*.

In January, I returned the poison slides to the American Association of Poison Control Centers and received a new set in exchange. Since there is practically no difference between the sets, and since the old ones had been shown throughout the state, we did not exhibit the new set.

Leaflets titled *10 Commandments of Shooting Safety* and *Citation Awards Program* were sent for and distributed at Board meetings.

MRS. JOSEPH W. REILLY, *Chairman*

Lillian W. Harris Scholarship Fund Committee

The following hospitals in Rhode Island received our two annual nursing scholarships: Rhode Island Hospital, $160.00, and Newport Hospital School of Nursing, $160.00. Both schools were very grateful for this aid.

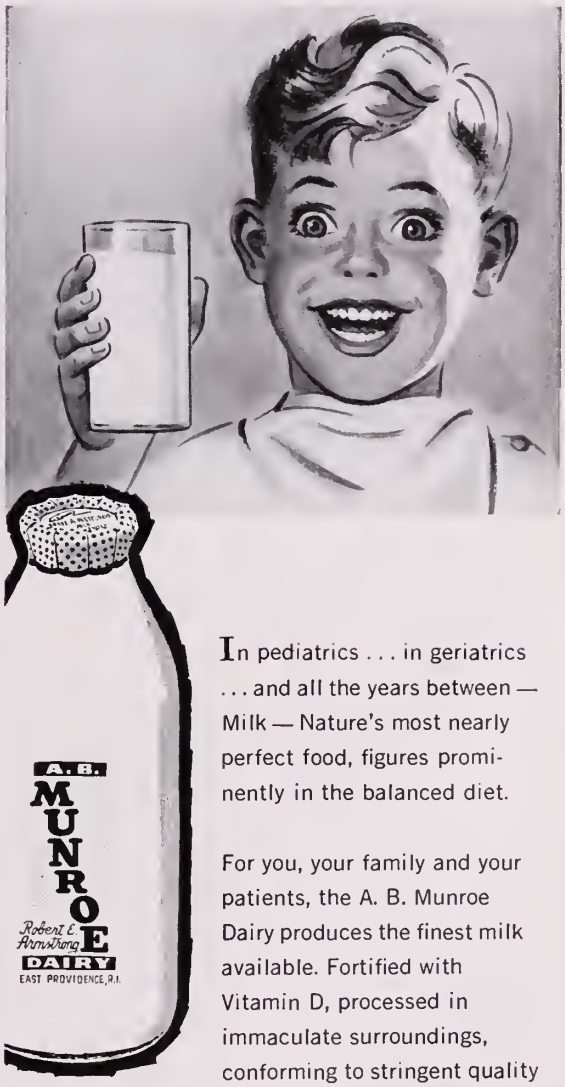
MRS. ARTHUR E. HARDY, *Chairman*

Sesquicentennial Committee

As this is a final report, it will be a factual, statistical one summarizing the activities of this

continued on next page

"your very good health"



In pediatrics . . . in geriatrics . . . and all the years between — Milk — Nature's most nearly perfect food, figures prominently in the balanced diet.

For you, your family and your patients, the A. B. Munroe Dairy produces the finest milk available. Fortified with Vitamin D, processed in immaculate surroundings, conforming to stringent quality requirements, A. B. Munroe milk is the ultimate in purity and safety.

RHODE ISLAND QUALITY MILK ASSOCIATION MEMBER

A. B. MUNROE DAIRY, INC.
151 Brow Street, East Providence, Rhode Island

Call GE 8-4450
for Home Delivery

committee. It was our pleasure to represent the Woman's Auxiliary on the Sesquicentennial Committee of the Rhode Island Medical Society, and to have the Auxiliary called upon, during this 150-year celebration of the Medical Society, to assist in the following areas: (1) mailing — pertaining to the Rhode Island Exposition of Health Progress; (2) staffing clerical help at polio booth — Health Exposition, and (3) student tours at Health Exposition.

1. Under the direction of Will Barbeau Associates, public relations firm engaged by the Medical Society for the Health Exposition, members of the committee and executive board assembled, addressed, and prepared for mailing envelopes which contained tickets, poster, and letter to all dentists and physicians in the state, to all industries in Rhode Island and nearby Massachusetts, and to all secondary schools, private, parochial, and public, in Rhode Island and nearby Massachusetts. This work was completed within four days and it was estimated to have saved the Medical Society Sesquicentennial Committee several hundred dollars.

2. A polio booth at the Health Exposition, offering free immunization against polio, sponsored jointly by the state Public Health Department and the Rhode Island Medical Society, was staffed with clerical help throughout the entire time of the Health Exposition — April 6 through April 15. Members of the Providence Association of Medical Assistants covered the late afternoon and evening hours Monday through Friday; weekends and early afternoons were covered by Auxiliary members and teen-age daughters of Auxiliary members.

3. Over 10,000 junior high school students from all parts of the state were conducted on tours at the Health Exposition Monday, April 9 through Friday, April 13 from 9 A.M. to 2:30 P.M. Morning tours were limited to 70 minutes due to the large number of tours in the morning groups, and afternoon tours were 90 minutes in length. A total of 341 tours were conducted during the week. 156 Auxiliary members and 16 members of the Providence Association of Medical Assistants served on bus detail or acted as guides for these tours. Members of the Auxiliary executive committee and members of this Sesquicentennial Committee were on duty at the Armory, Monday through Friday from 9 A.M. to 3 P.M.

A first-aid station set up by the Rhode Island Chapter, American Red Cross, was in charge of an Auxiliary member registered nurse during the hours of the school tours. A detailed copy of the "engineering and mechanics" of the student tours, for future reference as needed, is on file at the Medical Library.

Mrs. Mark A. Yessian, *Chairman*



Wherever you go forget your telephone calls. We'll take them for you, day or night.

MEDICAL BUREAU

of the

Providence Medical Association

Mrs. James P. O'Brien, *Co-chairman*
Mrs. Thomas Perry, Jr.,
School Scheduling and Transportation
Mrs. John T. Barrett, *Tours*
Mrs. John Turner, *Tours*
Mrs. Thomas Forsythe,
Volunteer Recorder
Mrs. Donald F. Larkin,
Clerical Help, Polio Booth

AREA REPRESENTATIVES

Providence . . . Mrs. George A. Ernst
Mrs. John B. Lawlor
Bristol . . . . . Mrs. H. Bickford Lang
Kent . . . . . Mrs. Bruno Franek
Newport . . . . . Mrs. William C. Hartnett
Pawtucket . . . Mrs. Alexander Jaworski
Washington . . Mrs. Samuel S. Farago
Woonsocket . . Mrs. Paul Cohen

Ways and Means Committee

The annual Dinner Dance held November 11, 1961 at the Providence Sheraton-Biltmore Hotel, was attended by approximately 150 couples. An excellent dinner was served at tables attractively decorated under the direction of Mrs. Arno Kiiss. Dancing was enjoyed to the music of Ed Drew's Orchestra.

Mrs. Carl Anderson was in charge of the raffle, with Mrs. Richard Haverly assisting her. A substantial sum was realized.

Mrs. John Cashman and Mrs. John Lawlor were in charge of reservations.

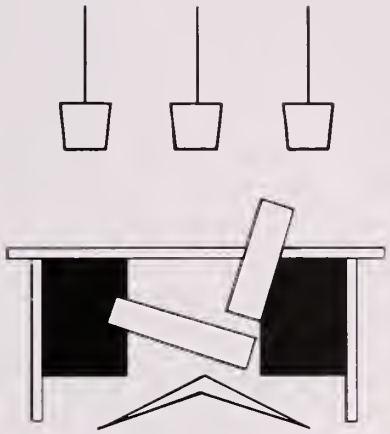
An atmosphere of friendliness and happy enjoyment contributed to the success of this, our one fund-raising activity of the year.

MRS. THOMAS PERRY, JR., *Chairman*

J. E. BRENNAN & COMPANY
Leo C. Clark, Jr., B.S., Reg. Pharm.
Apothecaries
Two Convenient Locations
5 North Union Street Pawtucket, R. I.
140 Central Avenue Seekonk, Mass.
7 Registered Pharmacists
Pharmacy License #226

PATRONIZE JOURNAL ADVERTISERS

Attractive & Functional Offices
by BENÉ & CO., INC.



Designers & Suppliers of Offices
150 Dorrance Street • Providence 3, R. I. • GAspee 1-5228

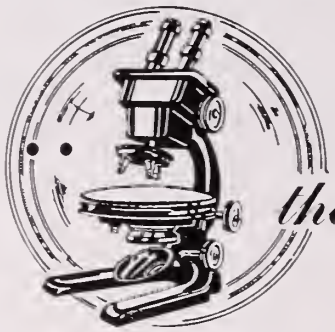
TESTIMANIMAL



Who gives a hoot for any drink but

WARWICK CLUB
GINGER ALE
It sings in the glass



THROUGH . . .  *the Microscope*

Dr. C. L. Farrell Receives Citation from OASI

Doctor Charles L. Farrell, of Pawtucket, received a "Director's Citation" on June 23, at Chicago, from the Bureau of Old Age and Survivors Insurance. The award is the highest given by the Bureau for superior contribution. Doctor Farrell is a charter member of the Medical Advisory Committee established in 1955 to work with the Bureau's Division of Disability Operations in developing medically sound policies and procedures for administering the social security disability insurance program. More than one million persons are now receiving monthly benefit payments, totaling $70 million dollars, under this program.

Auxiliary President Urges Members to Aim High

Physicians' wives must broaden the scope of their education and understanding if they are to know the satisfaction of meeting responsibilities to families, to communities and to the future, the new president of the Woman's Auxiliary to the American Medical Association said in her inaugural address.

In assuming the presidency, Mrs. William G. Thuss, Birmingham, Alabama, urged that members support medical education, promotion of safety education for all age groups, mental health, physical fitness programs in schools, campaigns against quackery, recruitment of outstanding young people into medical careers, rural health and international health activities.

Mrs. Thuss said that in its first 40 years the Auxiliary has accomplished a great deal as indicated by the "changed attitude of medical societies and the A.M.A., . . . we have become full partners and allies of our husbands."

Doctors' wives must continue to "aim for excellence in achievement" during the year ahead, she said.

Mrs. Thuss succeeds Mrs. Harlan English, Danville, Illinois. The new president-elect is Mrs. C. Rodney Stoltz, Watertown, South Dakota.

Other Auxiliary officers installed at the 39th annual convention in Chicago include: Mrs. Harry F. Pohlmann, Middletown, N.Y., first vice president; regional vice presidents — Mrs. Morton Arnold, Windham Center, Conn., eastern; Mrs. Richard A. Sutter, St. Louis, Mo., north central; Mrs. Robert D. Croom, Jr., Maxton, N.C., southern; Mrs. G. Prentiss Lee, Portland, Ore., western; Mrs. William H. Evans, Youngstown, Ohio, constitutional secretary, and Mrs. C. R. Pearson, Baraboo, Wis., treasurer.

New England Postgraduate Assembly in November

Doctor Robert Bradley of Boston has announced preliminary plans for the New England Postgraduate Assembly to be held in Boston, November 6, 7 and 8. The Assembly is now sponsored by the Council of the six New England state medical societies.

College of Obstetricians Announces Election of New Fellows

Four Rhode Island physicians were included in the list of new Fellows recently elected to the American College of Obstetricians and Gynecologists. The roster includes Doctors Edward L. Horan and William N. Pinault of Pawtucket, William A. McIntyre of North Providence, and Louis A. LaPere of Westerly.

The College is planning an annual meeting of Districts I and II to be held at the Queen Elizabeth Hotel in Montreal on October 11-13.

Sale of Candy and Soda in School Lunchrooms Opposed

The Council on Foods and Nutrition of the American Medical Association is opposed to the sale and distribution of confections and carbonated beverages in school lunchrooms.

The nutritional benefit of candy and soft drinks is "greatly inferior" to that of milk, fruit and other foods, the council said.

The full council statement:

concluded on page 435



a relaxed mind in a relaxed body

with

Trancopal®

Brand of chlormezanone

effective TRANQUILIZER ■ potent MUSCLE RELAXANT

When you prescribe Trancopal you can see how this "tranquilaxant" speedily helps the anxious patient. It quiets his psyche — and this quieting helps relax tense muscles. It eases muscle spasm — and this easing helps put the mind at rest.

DeNyse[1] notes that the effect of Trancopal as a quieting agent ". . . may play a part in the skeletal muscle relaxing results obtained." Gruenberg[2] used Trancopal to treat patients with musculoskeletal disorders, and commented: "In addition to relieving spasm and pain, with subsequent improvement in movement and function, Trancopal reduced restlessness and irritability in a number of patients."

Trancopal has an unsurpassed record of safety. Very few side effects occur with Trancopal. You may see them in only about two out of a hundred patients, and they will almost always be mild.

Available: 200 mg. Caplets® (green colored, scored), bottles of 100
100 mg. Caplets (peach colored, scored), bottles of 100

Dosage: Adults, 1 Caplet (200 mg.) three or four times daily;
children (5 to 12 years), from 50 to 100 mg. three or four times daily.

Before prescribing, consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

References: 1. DeNyse, D. L.: M. Times *87*:1512 (Nov.) 1959.
2. Gruenberg, F.: Current Therap. Res. *2*:1 (Jan.) 1960.

Winthrop LABORATORIES New York 18, N.Y.

1649M

FAMILY DAY

For Rhode Island Physicians, Their Wives and Children

SUNDAY . . . SEPTEMBER 23, 1962

COVENTRY PINES COUNTRY CLUB
(Harkney Hill Road, Coventry)

Activities Start at 1:30 P.M. . . .

Golf . . . Fishing . . . Baseball . . . Boccia . . . Horseshoes

CHICKEN BARBECUE (After Social Hour) . . . at 4:30 P.M.

A Wonderful Get-Together on a Strictly Informal Basis

Send in your reservation promptly to the Executive Office



Coca-Cola, too, is compatible with a well balanced diet. As a pure, wholesome drink, it provides a bit of quick energy . . . brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE-MARK ®

THROUGH THE MICROSCOPE

concluded from page 432

"One of the functions of a school lunch program is to provide training in sound food habits. The sale of foods, confections, and beverages in lunchrooms, recreation rooms, and other school facilities influences directly the food habits of the students. Every effort should be extended to encourage students to adopt and enjoy good food habits.

"The availability of confections and carbonated beverages on school premises may tempt children to spend lunch money for them and lead to poor food habits. Their high energy value and continual availability are likely to affect children's appetites for regular meals. Expenditures for carbonated beverages and most confections yield a nutritional return greatly inferior to that from milk, fruit, and other foods included in the basic food groups.

"When given a choice between carbonated beverages and milk or between candy and fruit, a child may choose the less nutritious.

"In view of these considerations, the Council on Foods and Nutrition is particularly opposed to the sale and distribution of confections and carbonated beverages in school lunchrooms."

Rhode Island Blue Plans Record Highest Enrollment

Blue Cross and Physicians Service memberships have reached new all-time highs.

Blue Cross membership was recorded at 657,103 persons in June which was an increase of 16,648 over the same month last year, and a gain of 12,410 over the previous month.

Physicians Service membership neared the 600,000 mark for the first time, as a total of 597,755 persons were enrolled. The surgical plan membership is 21,676 higher than the previous year, and an increase of 13,667 over the prior month.

The major reason for the gains was the net addition of members who joined during the plans' recent open enrollment campaign, with memberships becoming effective last month.

Rhode Island Blue Cross has approximately 80 per cent of the eligible state population enrolled.

Almost 70 per cent of the eligible population is enrolled under Physicians Service, the local Blue Shield Plan.

Patronize Journal Advertisers

Obstetrician-gynecologist wanted as associate for board certified ob-gyn. man in twelve doctor specialty group; salary minimum $14,000, early partnership; excellent clinical and hospital facilities; community of 14,000; fine schools; year-round recreation includes hunting, fishing, boating, skiing, etc.

Contact: H. B. Cope, M.D., Lemont-Peterson Clinic, Virginia, Minnesota.

Curran & Burton, Inc.

INDUSTRIAL
AND WHOLESALE

COAL **OIL**

17 CUSTOM HOUSE STREET
PROVIDENCE, R. I.
DExter 1-3315

LIFE INSURANCE or DEATH INSURANCE?

SOME Medical men need DEATH Insurance ONLY.

Others need accumulating, guaranteed dollar values to meet their LIVING needs in the future — DEPRESSION — EMERGENCY — RETIREMENT, etc.

In any event, our new "CHEAPER-THAN-TERM" DEATH INSURANCE is the first step in the right direction!

Don't make any important changes in your Life Insurance or Estate plans without investigating "CHEAPER-THAN-TERM"!

For further information about this sensational new development in DEATH INSURANCE, write or phone:

ROLAND A. DEROSIER
54 Custom House Street
Providence 3, Rhode Island
TE 1-4833

Certified MILK

THE AMERICAN ASSOCIATION OF MEDICAL MILK COMMISSIONS SUPERVISES THE PRODUCTION OF

Certified MILK



1. CLEANER. Lowest bacteria-count. Milk checked before each milking. All utensils, bottles, and equipment sterilized before use.

2. BETTER-PROTECTED. Strictest medical supervision of herds and employees. Frequent examinations and laboratory-control AT THE FARM are required.

3. AUTOMATIC MILKING. Cows are milked automatically by electric machine. Milk is bottled without exposure to air or human touch.

4. BOTTLE CLOSURES. Must be of the highest quality to provide complete protection for the milk and bear approval of The American Association of Medical Milk Commissions.

5. MORE NUTRITIOUS. Cows scientifically fed balanced ration. Nutrition control from soil to delivery of milk. Same diet all year.

6. LONGER-LASTING, BETTER-TASTING. Diet control, special handling, and shortest time of delivery from cow to consumer assure fine fresh flavor that lasts for weeks.

7. THE DOCTOR'S MILK. Produced, processed, bottled on farms supervised by Medical Milk Commissions. Each bottle bears the seal of the A.A.M.M.C. and names of the supervising Commission and producing farm.

MILK COMMISSION OF PROVIDENCE MEDICAL ASSOCIATION

HILLSIDE FARMS, INC., 1308 Phenix Ave., Cranston, WI 2-3400
Produced at Hillside Farm, Cranston, R. I.

H. P. HOOD & SONS, 135 Harris Ave., Providence, DE 1-3024
Produced at Hood Certified Farm, Beverly, Mass.

WHITING MILK CO., 40 Tockwotton St., Providence, GA 1-5363
Produced at Hampshire Hills Farm, Wilton, N. H.

The extra-firm mattress selected by over 9,000 doctors for their own use

sures both preventive and corrective support—used in re American homes than any other special design

ly Posturepedic is the first mattress designed in cooperation h leading orthopedic surgeons to promote normal, healthful p among *all* persons.

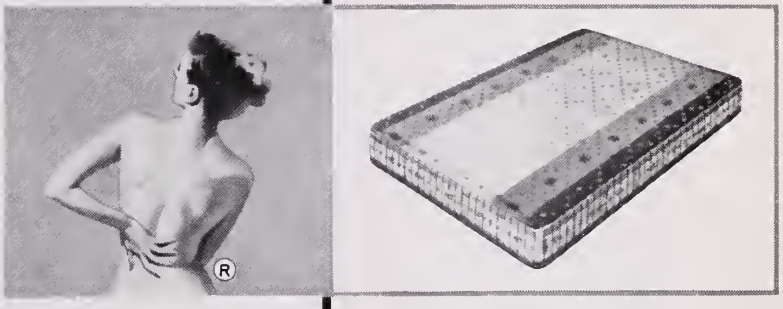
a "corrective device" it serves those chronically afflicted with er back syndromes. As a preventive measure Sealy Posturepedic ngs deep spring buoyancy without bedboard hardness to every- —plus the concomitant blessings of unexcelled comfort and ra-firm support.

ese are basic to good health. The therapeutic value of restful ep is especially recognized during these tense and anxious days. ly Posturepedic eminently meets this need by supplying level ne support for proper relaxation of the limbs and human mus- atory system.

er 9,000 doctors of medicine have tried and bought the Sealy sturepedic mattress and matching foundation for their own use. e believe your investigation will firmly convince you of its dis- ctive benefits, and, we would hope, merit your valued recom- endation.

Sealy POSTUREPEDIC® BRAND

NO MORNING BACKACHE
from a too-soft mattress



PROFESSIONAL DISCOUNT OF $39.00

o that you may judge the quality of the Sealy Posturepedic for yourself, e offer a special Professional Discount on this mattress and foundation hen purchased for your personal use. *Limit—one full or two twin size sets.*

EALY MATTRESS COMPANY • Oakville, Conn.

closed is my check and letterhead. Please ship the Sealy Posturepedic Set(s) icated below:

1 Full Size ☐ **1 Twin Size ☐** **2 Twin Size ☐**

	RETAIL		PROFESSIONAL
sturepedic Mattress	each $79.50	(add state tax)	$60.00
sturepedic Foundation	each $79.50	(add state tax)	$60.00

ME_____

SIDENCE_____

Y_____ ZONE____ STATE_____

(This is a saving of $39.00 per set over the regular $159.00 retail price for mattress and matching foundation)

©Sealy, Inc., 1958



To help you and your family build systematically and surely for the future

A new type of trust service from Industrial National Bank

THE BUDGET TRUST

NOW INDUSTRIAL NATIONAL offers you a personal budget plan to help you build for the future — a budget plan you can start on right now! It's a new type of trust service — *The Budget Trust.*

How your Budget Trust works

You start your Budget Trust with $100 or more. Then you make regular planned deposits. It may be as little as $25 a month.

Your funds are invested in common stocks selected primarily with an eye to long-term growth rather than current income. Your lawyer draws the Trust Agreement — and Industrial National acts as your trustee. All income earned is added to your Budget Trust and reinvested. The continuous inflow of funds gives you the maximum advantage of dollar-cost-averaging.

Flexibility of your Budget Trust

Your Budget Trust is revocable at any time, in part or in whole. You may withdraw any part of your funds on quarterly withdrawal and entry dates.

You will discover, though, that a Budget Trust — with its systematic deposit feature — will make it much easier for you to accumulate the funds you need for your long-range goals. It's something important to consider when you think ahead to your retirement, your children's education, or any other years-from-now project.

Your Budget Trust brings you the benefits of Industrial National's broad investment and trust experience. One of our trust officers will be glad to discuss the new Budget Trust with you. To learn more about the Budget Trust, visit any Industrial National office, or call Mr. Allingham at JA 1-9700.

INDUSTRIAL
NATIONAL BANK OF
RHODE ISLAND

45 Neighborhood Offices Serving Rhode Island

Member Federal Reserve System
Member Federal Deposit Insurance Corporation

RHODE ISLAND

SEPTEMBER, 1962

Medical Journal

The 21st Chapin Oration:
Eradication of Poliomyelitis
ALBERT B. SABIN, M.D.
See page 453

Volume XLV, No. 9
Table of Contents, page 439



. . . even though surrounded by allergens. Co-Pyronil® provides smooth, continuous control of allergic symptoms—relief in minutes for hours, with virtually no side-effects. And there is a dosage form for every allergic patient.

Pulvules®
Suspension
Pediatric Pulvules

Co-Pyronil®
(pyrrobutamine compound, Lilly)

Each Pulvule contains Pyronil® (pyrrobutamine, Lilly), 15 mg.; Histadyl® (methapyrilene hydrochloride, Lilly), 25 mg.; and Clopane® Hydrochloride (cyclopentamine hydrochloride, Lilly), 12.5 mg. Each pediatric Pulvule or 5-cc. teaspoonful of the suspension contains half of the above quantities. This is a reminder advertisement. For adequate information for use, please consult manufacturer's literature. Eli Lilly and Company, Indianapolis 6, Indiana.

Lilly

258015



only herself to talk to..



DILANTIN

(diphenylhydantoin, Parke-Davis)

enables the epileptic to engage in everyday activiti

In grand mal and psychomotor seizures, DILANTIN is the dr of choice for a variety of reasons: • effective control of gra mal and psychomotor seizures[1-9] • oversedation is not a proble • possesses a wide margin of safety[3] • low in incidence of si effects[3] • its use is often accompanied by improved memor intellectual performance, and emotional stability[10] •DILANT is available in several forms, including DILANTIN Sodium Ka seals,® 0.03 Gm. and 0.1 Gm., bottles of 100 and 1,000.

and in petit mal epilepsy...

ZARONTIN®

(ethosuximide, Parke-Davis)

Clinically proved to be of si nificant value in the treatme of petit mal epilepsy,[11-] ZARONTIN provides high le els of seizure control, even in intractable cases. ZARONT is available in capsules, 0.25 Gm., bottles of 100.

Other members of the PARKE-DAVIS FAMILY OF ANTICONVU SANTS for grand mal and psychomotor seizures: PHELANTI Kapseals (Dilantin 100 mg., phenobarbital 30 mg., desox ephedrine hydrochloride 2.5 mg.), bottles of 100, for the pe mal triad: MILONTIN® Kapseals (phensuximide, Parke-Davi 0.5 Gm., bottles of 100 and 1,000; Suspension, 250 mg. per 4 c 16-ounce bottles. CELONTIN® Kapseals (methsuximide, Park Davis) 0.3 Gm., bottles of 100.

BIBLIOGRAPHY: (1) Roseman, E.: *Neurology* 11:912, 1961. (2) Bray, P. F.: *Pediat* 23:151, 1959. (3) Chao, D. H.; Druckman, R., & Kellaway, P.: Convulsive Disorders of Child Philadelphia, W. B. Saunders Company, 1958, p. 120. (4) Crawley, J. W.: *M. Clin. No America* 42:317, 1958. (5) Livingston, S.: The Diagnosis and Treatment of Convulsive I orders in Children, Springfield, Ill., Charles C Thomas, 1954, p. 190. (6) *Ibid.*: *Postgrad. M* 20:581, 1956. (7) Merritt, H. H.: *Brit. M. J.* 1:666, 1958. (8) Carter, C. H.: *Arch. Neu & Psychiat.* 79:136, 1958. (9) Thomas, M. H., in Green, J. R., & Steelman, H. F.: Epile Seizures, Baltimore, The Williams & Wilkins Company, 1956, pp. 37-48. (10) Goodman, L. & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmil Company, 1955, p. 187. (11) Heathfield, K. W. G., & Jewesbury, E. C. O.: *Brit. M. J.* 2: 1961. (12) Zimmerman, F. T., & Burgemeister, B. B.: *Neurology* 8:769, 1958. (13) Gordon, *Neurology* 11:266, 1961. (14) Dongier, M.; Dongier, S.; Gastaut, H., & Roger, J.: *Rev. neu* 104:341, 1961.

This advertisement is not intended to provide complete information f use. Please refer to the package enclosure, medical brochure, or write for detailed information on indications, dosage, and precautions.

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit 32, M

0



RHODE ISLAND
HOSPITAL TRUST COMPANY
Member F D I C

Need an experienced guide through the "market maze?"

Today's busy investor, no matter how experienced, is likely to lack the time to find and analyze facts. Without this information the investment field can become a worrisome maze indeed.

The solution? Many Rhode Islanders find it in an *Investment Management Account* at Hospital Trust. Our advice to buy or sell securities is objective and—thanks to continuing research performed by experienced specialists — *informed*. In addition, our Trust Department tends to the details of investing, watches for important deadlines, collects and pays out income as directed.

The cost of an *Investment Management Account* is moderate. And except to the extent that tax-exempt bonds are involved, our charges are deductible for income tax purposes. Stop in soon for details.



RHODE ISLAND
HOSPITAL TRUST
COMPANY
New England's Oldest Trust Company

OFFICES IN PROVIDENCE • CRANSTON • EAST PROVIDENCE • BRISTOL • EAST GREENWICH • NEWPORT • PAWTUCKET • WAKEFIELD • WOONSOCKET • WARWICK

The RHODE ISLAND MEDICAL JOURNAL

Editorial and Business Office: 106 Francis Street, Providence, R. I.

Editor-in-Chief: SEEBERT J. GOLDOWSKY, M.D.

Managing Editor: JOHN E. FARRELL, SC.D.

Senior Editors

ALEX M. BURGESS, SR., M.D. HENRI E. GAUTHIER, M.D.

Advisory Board

(in addition to editors listed above)

JOHN A. DILLON, M.D. JOHN F. W. GILMAN, M.D. ROBERT V. LEWIS, M.D.
PETER L. MATHIEU, M.D. JOSÉ M. RAMOS, M.D. ROBERT W. RIEMER, M.D.
JACK SAVRAN, M.D. LESTER L. VARGAS, M.D.

Owned and Published Monthly by

THE RHODE ISLAND MEDICAL SOCIETY

Second-class postage paid at Providence, Rhode Island

Copyright, 1962, the Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island

Single copies, 25 cents . . . Subscription, $2.00 per year.

Volume XLV, No. 9 September, 1962

TABLE OF CONTENTS

PAGE

ERADICATION OF POLIOMYELITIS — PRESENT STATUS AND FUTURE PROSPECTS — 21st Charles V. Chapin Oration, *Albert B. Sabin,* M.D. 453

THE SURGICAL TREATMENT OF STENOSIS AND THROMBOSIS OF THE EXTRACRANIAL PORTIONS OF THE CAROTID ARTERIES, *Charles Rob,* M.D. 463

REPORT OF ACTIONS OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION, *Charles J. Ashworth,* M.D., AND *Arthur E. Hardy,* M.D. 472

EDITORIALS

The New Frontier in Poliomyelitis Prevention 467

Mechanical Medicine — "Tender Loving Care" by Machine? 467

The Doctors' Right to Lobby 468

DEPARTMENTS

Press Editorializes on Medicare Legislation 444

Gerber Oration Announcement 462

John F. Kenney Clinic Day Program 466

Recent Clinical Advances in Pediatrics, Program of Roger Williams General Hospital Symposium 477

Through the Microscope 478

Books Received for Review 484

asthma attack averted
. . . in minutes

patient protected
. . . for hours





Nephenalin®

(the dual-action anti-asthmatic tablet)

. . . works with nebulizer speed—provides four-hour protection

One NEPHENALIN tablet provides: *air in a hurry*—through sublingual isoproterenol HCl, 10 mg. *air for hours*—through theophylline, 2 gr.; ephedrine, 3/8 gr.; phenobarbital, 1/8 gr.

Dosage: Hold one NEPHENALIN tablet under the tongue for five minutes to abort the asthmatic attack promptly. Then swallow the tablet core for four full hours' protection against further attack. Only one tablet should be taken every four hours. No more than five tablets in 24 hours.

Supplied: Bottles of 50 tablets. For children: NEPHENALIN Pediatric, bottles of 50 tablets.

Caution: Do not administer NEPHENALIN with epinephrine. The two medications may be alternated at 4-hour intervals. NEPHENALIN should be administered with caution to patients with hyperthyroidism, acute coronary disease, cardiac asthma, limited cardiac reserve, acute myocardial damage, and to those hypersensitive to sympathomimetic amines. Phenobarbital may be habit forming. THOS. LEEMING & CO., INC., New York 17, N.Y.



A new answer to one of America's leading health problems

60 DELICIOUS FOODS THAT MAKE WEIGHT CONTROL EASIER!

Here is a practical and down-to-earth method to help overcome obesity, the nation's No. 1 diet problem—and prime stealer of doctor's consultation time. Now a new group of 60 delicious Mott's Figure Control Food products uses the best of nutrition knowledge to create quality dishes, lower in calories by an average of 50%. Indicated calorie savings can be made pleasantly and accurately while eating normal-size portions by using these calorie-controlled foods in place of higher calorie dishes. Protein, vitamin and mineral food values are retained.

Low carbohydrate, low fat: Fats are largely extracted from meats and poultry in a way that cannot be done at home. Sauces and dressings are prepared with a high proportion of non-fat milk solids, vegetable colloids, all are delectably "natural" and tempting in flavor. Fruits, juices, desserts and sauces are prepared where indicated with non-caloric sweeteners—natural fruit values are intact, extra sugars reduced. The carbohydrate, protein and fat content appears on all labels along with the calorie count. Useful for diabetic diets, too.

Easy medical tool for doctors: Less need for drugs, no possible dangerous side effects, not even temporary dislocation of meal patterns. Figure Control Foods include: Soups, Meats & Poultry, Popular Sauces, Salad Dressings, Preserves, Syrup, Fruits, Drinks, Desserts and Sweeteners.

New Mott's Figure Control® Foods offer Good Eating at Half the Usual Calories

	Quantity	Figure Control Calories	"Regular" Food Calories
Apple-Grape Drink	½ cup	20	52
Five-Fruit Juice Breakfast Drink	½ cup	20	52
Braised Beef and Vegetables	6½ oz.	184	380
Meat Balls in Brown Gravy	3½ oz.	84	280
Chopped Chicken Livers	1 oz.	31	100
Chicken a la King	3 oz.	72	230
French Style Dressing	1 tbsp.	10½	60
Brown Gravy	1 tbsp.	7	21

	Quantity	Figure Control Calories	"Regular" Food Calories
Applesauce	½ cup	48	90
Fruit Cocktail	½ cup	44	90
Cherry Pie Filling	1 oz.	20	60
Chocolate Topping	1 tbsp.	8	63
Preserves (Peach, Strawberry)	1 tbsp.	9	55
"Maplette" Syrup	1 tbsp.	9	55
Liquid or Powder Sweetener	(to equal 1 tbsp. of sugar)	0	16



Complete menus, recipes, calorie chart available for professional distribution, with weight control guides you can distribute with confidence: all menus meet N.R.C. Recommended Daily Allowances. **Use this handy order form:**

FIGURE CONTROL FOODS
Duffy-Mott Company
370 Lexington Avenue
New York 17, New York

Please send____free copies of YOUR WEIGHT CONTROL PLAN for use with patients.

Dr._____

Address:_____

City:_____ Zone:____ State:_____



THE AMERICAN ASSOCIATION OF MEDICAL MILK COMMISSIONS SUPERVISES THE PRODUCTION OF

Certified MILK



1. CLEANER. Lowest bacteria-count. Milk checked before each milking. All utensils, bottles, and equipment sterilized before use.

2. BETTER-PROTECTED. Strictest medical supervision of herds and employees. Frequent examinations and laboratory-control AT THE FARM are required.

3. AUTOMATIC MILKING. Cows are milked automatically by electric machine. Milk is bottled without exposure to air or human touch.

4. BOTTLE CLOSURES. Must be of the highest quality to provide complete protection for the milk and bear approval of The American Association of Medical Milk Commissions.

5. MORE NUTRITIOUS. Cows scientifically fed balanced ration. Nutrition control from soil to delivery of milk. Same diet all year.

6. LONGER-LASTING, BETTER-TASTING. Diet control, special handling, and shortest time of delivery from cow to consumer assure fine fresh flavor that lasts for weeks.

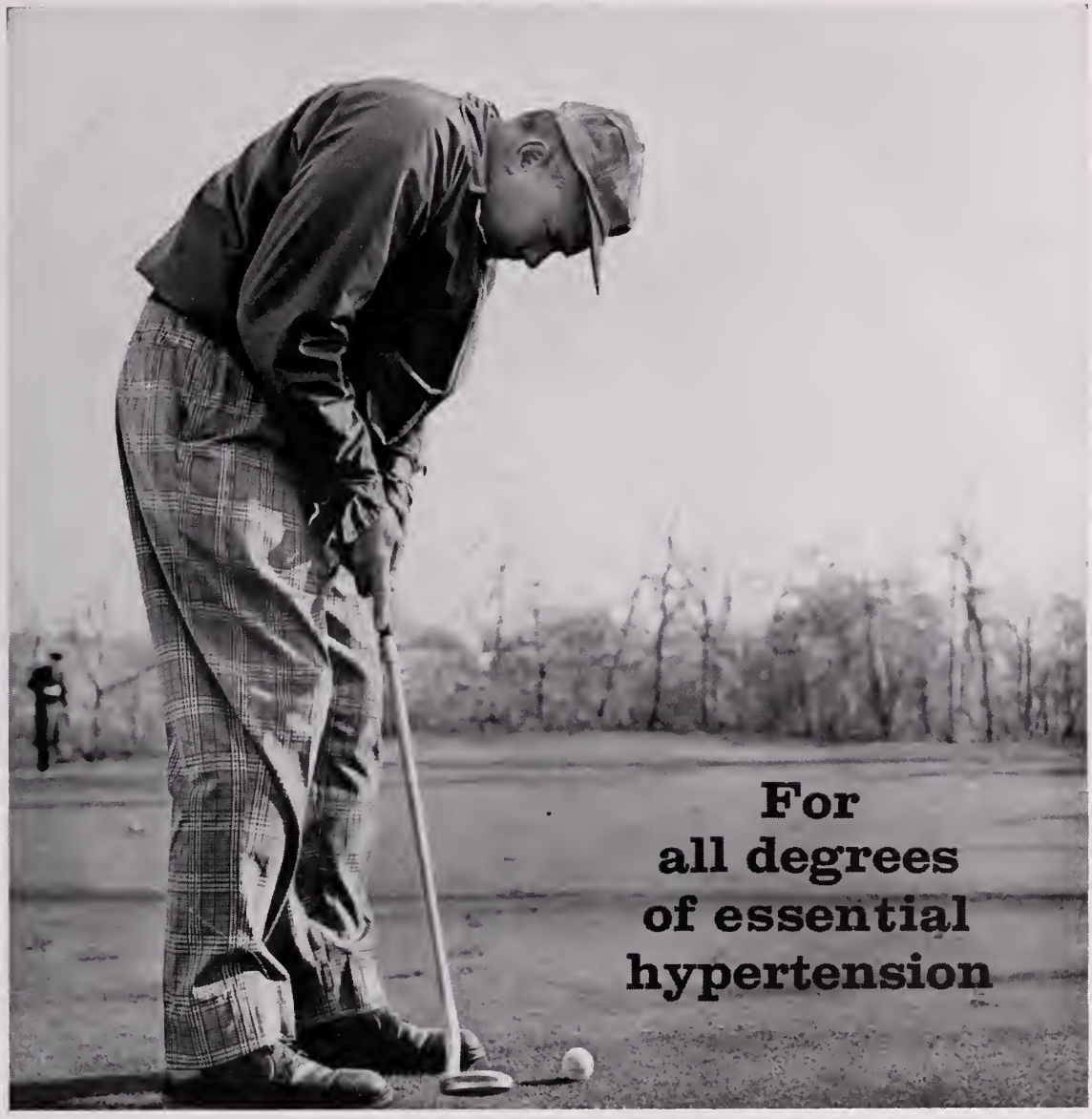
7. THE DOCTOR'S MILK. Produced, processed, bottled on farms supervised by Medical Milk Commissions. Each bottle bears the seal of the A.A.M.M.C. and names of the supervising Commission and producing farm.

MILK COMMISSION OF PROVIDENCE MEDICAL ASSOCIATION

HILLSIDE FARMS, INC., 1308 Phenix Ave., Cranston, WI 2-3400
Produced at Hillside Farm, Cranston, R. I.

H. P. HOOD & SONS, 135 Harris Ave., Providence, DE 1-3024
Produced at Hood Certified Farm, Beverly, Mass.

WHITING MILK CO., 40 Tockwotton St., Providence, GA 1-5363
Produced at Hampshire Hills Farm, Wilton, N. H.



"relief of symptoms is striking with Rautrax-N"†

Rautrax-N decreases blood pressure for almost all patients with mild, moderate or severe essential hypertension. Rautrax-N also offers a new sense of relaxation and well-being in hypertension complicated by anxiety and tension. And in essential hypertension with edema and/or congestive heart failure, Rautrax-N achieves diuresis of sodium and chloride with minimal effects on potassium and other electrolytes.

Rautrax-N combines Raudixin (antihypertensive-tranquilizer) with Naturetin c̄ K (antihypertensive-diuretic) for greater antihypertensive effect and greater effectiveness in relief of hypertensive symptoms than produced by either component alone. Rautrax-N is also flexible (may be prescribed in place of Raudixin or Naturetin c̄ K) and economical (only 1 or 2 tablets for maintenance in most patients).

Supply: Rautrax-N — capsule-shaped tablets providing 50 mg. Raudixin, 4 mg. Naturetin and 400 mg. potassium chloride. *Rautrax-N Modified* — capsule-shaped tablets providing 50 mg. Raudixin, 2 mg. Naturetin and 400 mg. potassium chloride.

†Hutchison J. C.: Current Therap. Res. *2*:487 (Oct.) 1960.

For full information, see your Squibb Product Reference or Product Brief.

Rautrax-N*

Squibb Standardized Rauwolfia Serpentina Whole Root (Raudixin) and Bendroflumethiazide (*Naturetin) with Potassium Chloride

SQUIBB *Squibb Quality — the Priceless Ingredient*

SQUIBB DIVISION Olin

'RAUDIXIN'®, 'RAUTRAX'®, AND' NATURETIN'® ARE SQUIBB TRADEMARKS.

THE PRESS EDITORIALIZES ON MEDICARE LEGISLATION

From the PROVIDENCE JOURNAL
July 21, 1962

NEVERTHELESS, millions of Americans have no protection or little protection against hospital bills at an age when they need protection most. Providing protection by raising Social Security taxes is among reasonable ways because it is pay-as-you-go protection. But Congress won't have it — at least, not now.

Defeat of protection under Social Security poses a question for Rhode Island, which is among 28 states not participating in the medical aid to the aged program provided under the Kerr-Mills Act. Under this matching program, the medically indigent aged receive as much hospital care as the participating states elect to give them. The federal government disburses about $180,000,000 among the 22 participating states, New York receiving about $17,000,000 and Massachusetts, $5,000,000. While Rhode Island does not participate, it helps pay for the program in these other states.

The new Rhode Island administration elected in November should consider joining the MAA program under Kerr-Mills. It would cost the state considerable sums in matching funds, but at least some of the state's aged would be helped in meeting hospital costs. In view of demonstrated congressional fickleness toward health care under Social Security, it is doubtful that Rhode Island would be wise to wait any longer for congressional enactment of the equivalent of a King-Anderson bill.

From the NEW YORK DAILY NEWS
July 18, 1962
Medicare Bites the Dust

After all the sound, fury, and victory predictions by Senator MIKE MANSFIELD, Democrat, of Montana, President Kennedy's pet plan for social security-linked partial hospital and nursing home care for some of the aged went down to defeat in the Senate yesterday.

The administration hoped to slide the medicare plan through the Senate by tacking it as an amendment to a bill on revision of the public welfare laws, already passed by the House.

This maneuver failed. Senator ROBERT S. KERR, Democrat, of Oklahoma, moved to table the medicare amendment. The Kerr motion passed by a full Senate vote of 52 to 48. A motion to reconsider was defeated by voice vote.

Medicare, then is dead — barring a near miracle — for this session of Congress. And President Kennedy's chances of selling the 87th Congress on various other pet measures of his don't look too bright.

We feel a bit sorry for J.F.K. But we think his loss is the taxpayers' — including in the long run the so-called senior citizens' — gain.

From the NEW YORK HERALD TRIBUNE
July 18, 1962
Defeat and Medicare

The Senate's defeat of medicare was a shattering blow to the Kennedy legislative program. But if the President regards it as no more than this, he will be missing half the point. It also was a well-merited rebuff to the Kennedy legislative tactics.

Medicare is one of the most complex and controversial issues to come before Congress in years. There can be no simple assessment of its merits, no quick top-of-the-head choice among the various alternative means of meeting the medical needs of the elderly.

These needs are increasing; more people live longer — thanks to the skills of the medical profession — and thus are subject for longer periods to the ills of old age while passing more years on what frequently is meager retirement income; at the same time, the cost of medical services is rapidly rising. Serious illness can mean financial catastrophe, with no means of recouping. The problem is a real one.

But whether the problem is best met by compulsory insurance under social security is a tough question. There is a real danger of overburdening the social security system itself. Though many doctors' opposition has been excessively strident, the fact of this opposition is a factor that has to be weighed — the quality of medical care for the entire population could be undermined if teaching, largely conducted in hospitals, suffers, or if promising young would-be doctors turn away discouraged.

For better or for worse, medical care depends on the medical profession. And it's worth remembering that the medical profession has given this country the best medical care ever enjoyed by any people anywhere.

concluded on page 448



"opened nose clear to the ears"[1]



This was how one patient described the nasal decongestant action of Dimetapp Extentabs. How would *your* patients describe it? From the first tablet, Dimetapp Extentabs provide prompt and prolonged relief from the stuffiness, drip and congestion of upper respiratory conditions, with exceptional freedom from side effects. The reason is in the formula: the potent antihistamine with side effects as few as placebo,[2] DIMETANE® (brompheniramine maleate, 12 mg.) and two outstanding decongestants, phenylephrine HCl (15 mg.) and phenylpropanolamine HCl (15 mg.)...all in dependable, long-acting Extentab form.

NEW DIMETAPP ELIXIR (one-third the Dimetapp Extentabs' formula in each 5 cc.), for conventional t.i.d. or q.i.d. dosage in a palatable, grape-flavored vehicle.

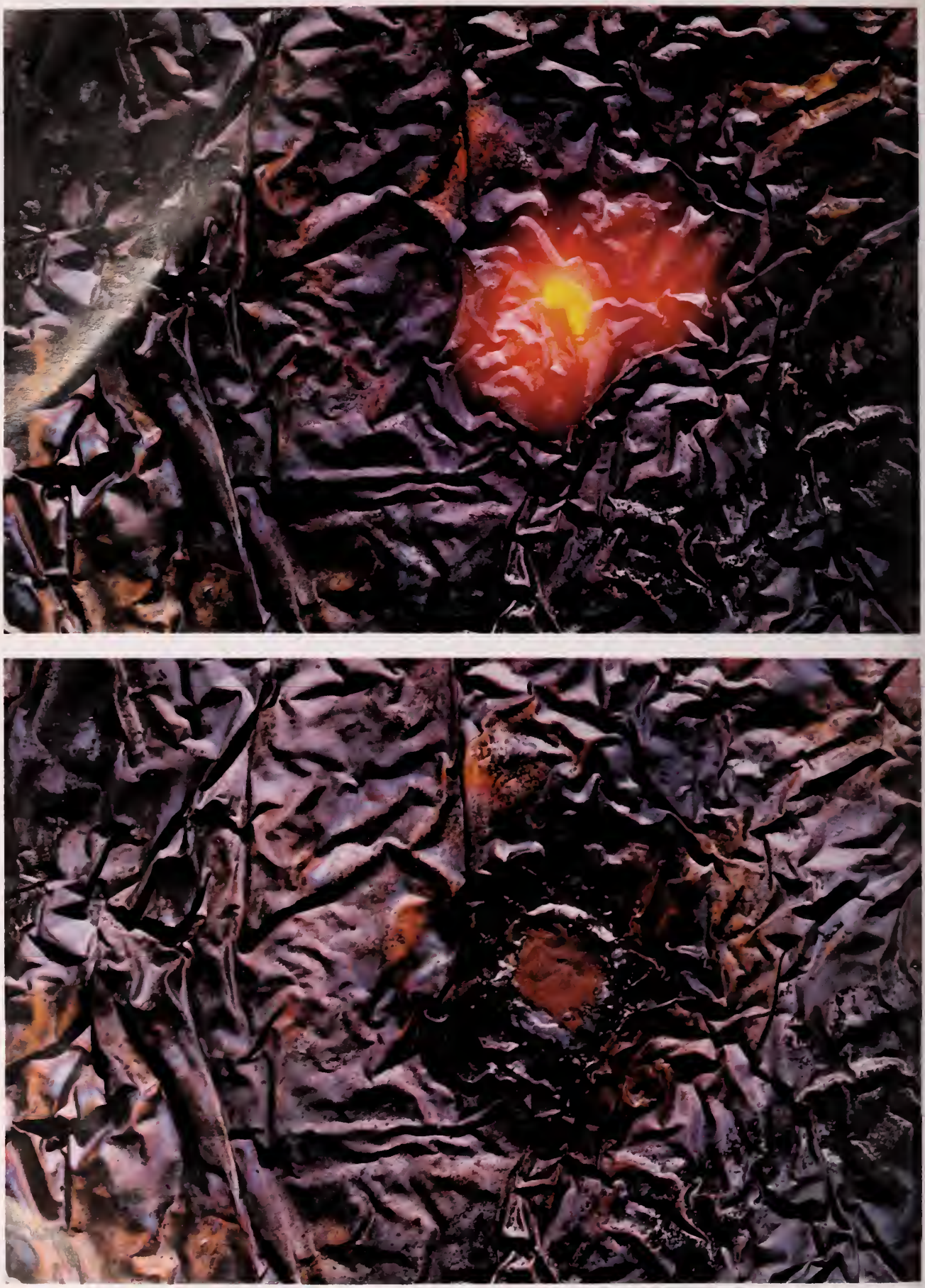
References: 1. Clinical report on file, Medical Department, A. H. Robins Co., Inc. 2. Schiller, I. W., & Lowell, F. C.: New England J. Med. *261*:478, 1959.

for nasal decongestion **Dimetapp® Extentabs®**

in sinusitis, colds, u.r.i., up to 10-12 hours' clear breathing on one tablet

PHARMACEUTICALS RESEARCH

A. H. ROBINS CO., INC., RICHMOND 20, VA.



The illustration: To dramatize the pain and trauma and healing of the peptic ulcer, our photographer burned a "lesion" into crumpled metal with a blowtorch and photographed it, then repaired the damage and rephotographed the result — the "healed" ulcer.

ulcer under repair

"What results can I expect in my ulcer patients?" Shown below is a tabulation of 795 ulcer patients, reported by 69 investigating physicians, in which glycopyrrolate was the anticholinergic employed. They represent a cross section of ulcer patients of all ages, both ambulatory and hospitalized, under various regimens, from all sections of the country.

Note the pattern of results. Robinul showed an "excellent" or "good" response in over 83% of patients, and Robinul-PH provided similar results in 81%.

As for side effects, these often troublesome extensions of anticholinergic action such as dry mouth, blurred vision, etc., were evaluated as "moderate-to-severe" in only 6.7% of a total of 1705 patients in preliminary investigative studies, 795 of whom are the ulcer cases tabulated here.

We invite you to try Robinul in your own practice. We believe you will find it one of the most effective agents you have ever used for the management of the ulcer patient.

Robinul® (formerly Robanul)
Each tablet contains glycopyrrolate, 1.0 mg.

Robinul®-PH (formerly Robanul-PH)
Each tablet contains glycopyrrolate, 1.0 mg.; and phenobarbital (¼ gr.), 16.2 mg.

Robinul® at work

Brand of glycopyrrolate, Robins

results with Robinul and Robinul-PH in 795 ulcer patients, from 69 clinical investigators*

DIAGNOSIS	ROBINUL					ROBINUL-PH				
	*No. Patients	Excellent	Good	Fair	Poor	*No. Patients	Excellent	Good	Fair	Poor
Marginal Ulcer	11	3	3	3	2	1	0	1	0	0
Pyloric Channel Ulcer	6	3	1	0	2	2	1	1	0	0
Pyloric Ulcer	4	2	1	1	0	1	1	0	0	0
Gastric Ulcer, bleeding	3	1	2	0	0					
Gastric Ulcer	48	31	11	1	5	12	5	7	0	0
Gastric Ulcer, penetrated	1	0	1	0	0	1	1	0	0	0
Gastric Ulcers, multiple	1	1	0	0	0					
Duodenal Ulcer	494	220	195	48	31	99	41	38	13	7
Duodenal Ulcer, bleeding	38	19	15	3	1	2	1	0	1	0
Duodenal Ulcer, obstruction	13	4	3	1	5					
Duodenal Ulcer, perforated	5	2	1	0	2	6	0	3	1	2
Gastric and Duodenal Ulcer	4	2	2	0	0					
Peptic Ulcer, unspecified	25	19	4	0	2	18	8	7	2	1
TOTALS	653	307	239	57	50	142	58	57	17	10
		83.6%					81.0%			

*Clinical reports on file, A. H. Robins Company, Inc.

A. H. Robins Co., Inc.
Richmond 20, Virginia

If you have patients on a cholesterol depressant diet, this will be welcome news:

General Mills is now making available, through grocery stores, a Safflower Oil which is totally acceptable in the diet, and which is priced reasonably.

SAFF·O·LIFE
Safflower Oil



As you know, Safflower Oil is higher in poly-unsaturates and lower in saturated fats than any other type of readily available vegetable oil.

When an increased poly-unsaturated fatty acid intake is desirable, you can recommend Saff-o-life Safflower Oil. You can do so with the assurance that the patient will find it completely appetizing—clear, light and fresh-smelling—and priced at a level which poses no problem.

Ratio of Linoleates* to Saturates
*(Poly-Unsaturates)

SAFFLOWER OIL • 9.0 to 1.0
CORN OIL • 5.3 to 1.0
SOYBEAN OIL • 3.5 to 1.0
COTTONSEED OIL • 2.0 to 1.0
PEANUT OIL • 1.6 to 1.0

Physicians who wish recipes using Saff-o-life Safflower Oil are invited to write directly to General Mills, Inc. Address your inquiries to Professional Services Director, General Mills, Inc. Dept. 120, 9200 Wayzata Blvd., Minneapolis 26, Minnesota.



PERCODAN BRINGS *SPEED*...DURATION... AND DEPTH TO ORAL ANALGESIA

in the wide middle region of pain

PERCODAN®

(Salts of Dihydrohydroxycodeinone and Homatropine, plus APC) TABLETS

fills the gap between mild oral and potent parenteral analgesics

■ acts in 5-15 minutes ■ relief usually lasts 6 hours or longer ■ constipation rare ■ sleep uninterrupted by pain

Literature on request

Endo®

ENDO LABORATORIES
Richmond Hill 18, New York

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Federal law allows oral prescription. *Also Available:* Percodan®-Demi: the complete Percodan formula, but with only half the amount of salts of dihydrohydroxycodeinone and homatropine.

Each scored, yellow Percodan* Tablet contains 4.50 mg. dihydrohydroxycodeinone HCl, 0.38 mg. dihydrohydroxycodeinone terephthalate (warning: may be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. acetophenetidin, and 32 mg. caffeine.

*U.S. Pats. 2,628,185 and 2,907,768

PRESS EDITORIALIZES ON MEDICARE

concluded from page 444

CHICAGO TRIBUNE — *Arm Twisting*

Among the 21 Democrats voting in the Senate to kill President Kennedy's health care bill was Senator JENNINGS RANDOLPH, of West Virginia. His was accounted the key vote in the administration defeat, for, if he had obeyed the White House lobbyists, a deal insuring that another Democrat would join him would have resulted in a tie vote, thus averting the tabling of the bill.

But MR. RANDOLPH, although he favored the idea of health care through social security, objected to the administration's methods of bypassing the established committees and getting the measure before the Senate as a rider to a public welfare bill. He objected because the argument on this extraneous issue was holding up welfare payments to 60,000 West Virginians and because he thought the administration was less interested in helping elderly people than in fabricating a political issue.

From the PITTSBURGH (PA.) PRESS
July 22, 1962
Politics in Medicare

When President Kennedy's medical care bill was defeated in the Senate the other day, Mr. Kennedy blamed it on Republicans and a handful of Democrats.

The handful consisted of 21 of the 64 Democrats in the Senate, including the chairmen of 10 important committees. Quite a handful.

Eight of these antimedicare Democratic Senators are up for election in November. Two of the five Republicans who supported Mr. Kennedy also are candidates.

The President suggests medicare will be a top issue in the campaign. Loss of the bill was a "defeat" for every American family, he said. He has indicated he will campaign extensively in behalf of candidates who will support his program.

So we wonder: Will the President go into North Carolina, Arkansas, Arizona, Alabama, Louisiana, Oklahoma, Florida, and Georgia to campaign against Senators ERVIN, FULBRIGHT, HAYDEN, HILL, LONG, MONRONEY, SMATHERS, and TALMADGE, the Democrats from those States who voted against his bill and are candidates for reelection?

Will he go into California and New York and campaign in behalf of Senators KUCHEL and JAVITS, Republicans who supported his bill and are candidates?

We do not anticipate the President will do anything of the sort. Mr. Kennedy is a party politics man.

But if medicare is as much of an issue as he says it is, if he really believes the welfare of every American family is affected, he logically should favor those who backed the bill and oppose those who voted against it, regardless of party labels.

Otherwise, the whole controversy has the hollow sound of mere talking politics.

From the WASHINGTON (D.C.) STAR
July 19, 1962
Political Medicine

The political war touched off by the President's ill-advised statement after the defeat of the medical care bill is now in full swing. Perhaps this would have been inevitable without the Kennedy statement. But it is a spectacle which makes one wonder what the Democrats really wanted — medical care or a political issue.

In saying this, we attribute no lofty motives to the Republicans. Some of their comments are just as demagogic as those coming from the Democratic camp. But it was the President who fired the first shot.

The fact is that 21 Democratic Senators combined with 31 Republicans to kill the bill. The President said it was killed by the Republicans and a handful of Democrats — manifestly a distortion of fact. Of the 21 Democrats — a third of the party membership in the Senate — 10 are chairmen of major committees.



Health Havens

100 WAMPANOAG TRAIL
EAST PROVIDENCE, R. I.
438-4275

A Truly Modern, Intermediate Care Facility Providing the Ultimate in Nursing Home Care at Reasonable Rates

Prepared to accept and adequately care for many acute cases as well as the more general convalescent and nursing home patients. We are limited to adults.

Our Nursing Administrator, Mary E. Baxter, R.N., will be pleased to discuss patient care with you.

RELIEVE THE COLD SUPPRESS THE COUGH WITH NEW 'EMPRAZIL-C'

TABLETS

ANTITUSSIVE ▪ DECONGESTANT ▪ ANALGESIC

Each tablet contains:

Codeine Phosphate*	15 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Acetophenetidin	150 mg.
Aspirin (Acetylsalicylic Acid)	200 mg.
Caffeine	30 mg.

*Warning—may be habit forming.

Complete literature available on request.

Also available without codeine as

'EMPRAZIL'®

TABLETS



BURROUGHS WELLCOME & CO. (U.S.A.) INC., TUCKAHOE, N.Y.

Stelazine® will stop anxiety—but not your patient!
brand of trifluoperazine

To be truly useful in your office patients, an ataractic agent must not only relieve anxiety; it must also leave these patients sufficiently alert to engage in their normal activities.

'Stelazine' is such an agent. Its ability to relieve anxiety without producing appreciable sedation has been established in thousands of patients and documented by many published reports. Typical is the finding of Kolodny,[1] who concluded that the primary advantage of 'Stelazine' over many other tranquilizers seems to be "its ability to relieve symptoms of anxiety without undue interference with alertness."

When you wish to relieve anxiety, yet encourage the patient to engage in his normal activities, consider 'Stelazine'.

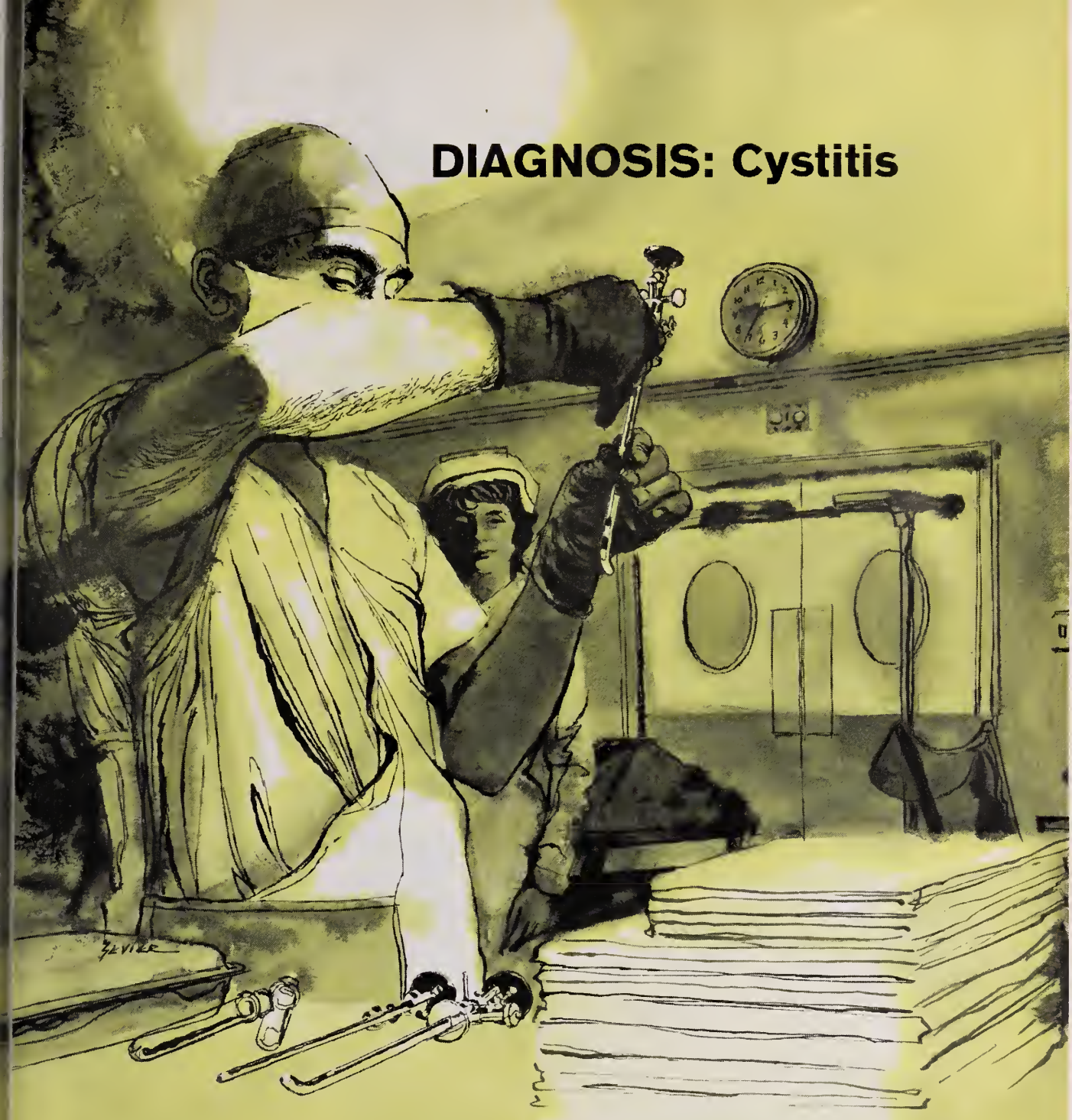
1. Kolodny, A.L.: Dis. Nerv. System *22*:151 (Mar.) 1961.

For prescribing information, please see *PDR* or available literature.

Smith Kline & French Laboratories, Philadelphia
leaders in psychopharmaceutical research

SK&F





THERAPEUTIC NEED: Suppression of the bacteriuria.

ANTIBIOTIC: DECLOMYCIN®

Demethylchlortetracycline Lederle

because it provides effective antibacterial activity in the urinary tract.

quest complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

EDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York Lederle

the first comprehensive regulator of female cyclic function

ENOVID®

(brand of norethynodrel with ethynylestradiol 3-methyl ether)



...unfettered

THE BASIC ACTION

ENOVID closely mimics the balanced progestational-estrogenic action of the functioning corpus luteum. This action is readily understood by a simple comparison. In effect, ENOVID *induces a physiologic state which simulates early pregnancy—except that there is no placenta or fetus.* Thus, as in pregnancy, the production or release of pituitary gonadotropin is inhibited and ovulation suspended; a pseudodecidual endometrium ("pseudo" because neither placenta nor fetus is present) is induced and maintained.

Further, during ENOVID therapy, certain symptoms typical of normal pregnancy may be noted in some patients, such as nausea—which is usually mild and disappears spontaneously within a few days—breast engorgement, some degree of fluid retention, and often a marked sense of well-being. There is no androgenicity. ENOVID *is as safe as the normal state of pregnancy.*

THE BASIC APPLICATIONS

1. **Correction of menstrual dysfunction.** *Emergency* treatment of severe dysfunctional uterine bleeding is promptly effective following the administration of ENOVID in larger doses. *Cyclic* therapy with ENOVID controls less severe dysfunctional uterine bleeding. In amenorrhea *cyclic* therapy with ENOVID establishes a pseudodecidual endometrium providing the patient has endometrial tissue capable of response.

2. **Ovulation suppression (to suspend fertility).** For this purpose ENOVID is administered *cyclically,* beginning on day 5 through day 24 (20 daily doses). The ovary remains in a state of physiologic rest and there is no impairment of subsequent fertility. When ENOVID is prescribed for this *cyclic* use over prolonged periods, a total of twenty-four months should not be exceeded until continuing studies indicate that its present lack of undesired actions continues for even longer intervals. Such studies are now in their seventh year and will regularly be reviewed for extension of the present recommendation.

3. **Adjustment of the menses** for reasons of health (impending hospitalization for surgery, during treatment of Bartholin's gland cysts, acute urethritis, rectal abscess, trichomonal or monilial vaginitis), or other special circumstances considered valid in the opinion of the physician. For this purpose ENOVID may be started at any time in the cycle up to one week before expected menstruation. Upon discontinuation, normal cyclic bleeding occurs in three to five days.

4. **Endometriosis.** *Continuous* therapy with ENOVID corrects endometriosis by producing a pseudodecidual reaction with subsequent absorption of aberrant endometrial tissue.

5. **Threatened and habitual abortion.** ENOVID should be used as *emergency* treatment in *threatened abortion* although symptoms may occur too late to be reversible. *Continuous* therapy with ENOVID in *habitual abortion* is based on the physiology of pregnancy. ENOVID provides balanced hormone support of the endometrium, permitting continuation of pregnancy when endogenous support is otherwise inadequate.

6. **Endocrine infertility.** ENOVID has been used successfully in *cyclic* therapy of endocrine infertility, promoting subsequent pregnancy through a probable "rebound" phenomenon.

THE BASIC DOSAGE

Basic dosage of ENOVID is 5 mg. daily in *cyclic* therapy, beginning on day 5 through day 24 (20 daily doses). Higher doses may be used with complete safety to prevent or control occasional "spotting" or breakthrough bleeding during ENOVID therapy, or for rapid effect in the *emergency* treatment of dysfunctional uterine bleeding and threatened abortion.

ENOVID is available in tablets of 5 mg. and 10 mg. Literature and references, covering more than six years of intensive clinical study, available on request.

SEARLE *Research in the Service of Medicine*

The RHODE ISLAND MEDICAL JOURNAL

VOL. XLV SEPTEMBER, 1962 NO. 9

The Twenty-first Charles Value Chapin Oration

ERADICATION OF POLIOMYELITIS — PRESENT STATUS AND FUTURE PROSPECTS*

ALBERT B. SABIN, M.D.

The Author. *Albert B. Sabin, M.D., of Cincinnati, Ohio. Distinguished Service Professor of Research Pediatrics, University of Cincinnati College of Medicine; Chief, Division of Virology and Cancer Research, The Children's Hospital Research Foundation, Cincinnati, Ohio.*

THE WORK of Doctor Chapin, and of the other great sanitarians of his era, was responsible for the great decline in the misery and death caused by many of the infectious diseases in the economically advancing countries. However, as John Paul pointed out in his excellent eighteenth Chapin Oration, it is this very advance in sanitation which has in the last fifty years progressively increased the terrible consequences of infection with the polioviruses in one country after another.[1]

Even in Western Europe some countries have had their first big epidemics only about 15 years ago — in Eastern Europe only during the past ten years — and in much of Latin America, Asia, and Africa, poliomyelitis as a dreaded epidemic paralytic disease, has appeared only recently and is rapidly assuming serious proportions.

I believe therefore that Doctor Chapin would have been pleased to know that this unfortunate consequence of improved sanitation can now be brought under human control — that the knowledge is now available which gives us hope not only of reducing the incidence of paralytic poliomyelitis, but also of eradicating it under appropriate conditions.

In this lecture, I should like to describe what we have learned thus far of the conditions required for the eradication of this disease, which has undoubtedly existed in association with the human race since the earliest evolutionary times. It was only about twenty years ago that the *crucial* evidence became available that poliomyelitis is primarily an infection of the human alimentary tract. It was only about ten years ago that we learned that there were only three distinct immunologic types of poliovirus — and not some unmanageably larger number. Gradually it also became evident that polioviruses maintain themselves in nature by passing from one susceptible human being to another, and the possibility appeared that this chain of transmission might be broken if a sufficiently large number of the human intestinal tracts could be rendered unsuitable for the multiplication of these viruses. Only since the advent of the tissue culture methods in recent years, described by Enders[2] in his Chapin oration of 1955, did it also become possible to learn that some polioviruses were "bad" viruses, some "intermediate," and others relatively "good" viruses, in the sense that they multiplied in the intestinal tract where they caused practically no disease, but possessed a very limited, if any capacity, to damage those cells in the nervous system, whose destruction in large numbers is responsible for the paralysis.

These new methods also permitted the selection of the special viral particles, from whose progeny it was possible to prepare the live poliovirus vaccines[3] that now provide us the hope for eradication of this disease.

There is no question that the Salk, killed virus vaccine has greatly reduced the incidence of paralytic poliomyelitis wherever it has been used extensively, but there are many parts of the world where it has been used little or not at all. However, entirely aside from the fact that the live, attenuated poliovirus vaccines produce immunity when given by mouth instead of by injection, they have the following properties not possessed by killed virus vaccine that are of special importance for the complete elimination or eradication of the disease:[4]

1. Immunity can be produced quickly — within about a week — after swallowing of a single dose of any one of the three types of the virus. Two or three doses are needed to produce immunity against the three types of the virus causing the disease, but the very first dose of

continued on next page

*Delivered at the Sesquicentennial Meeting of the Rhode Island Medical Society, at Providence, Rhode Island, May 8, 1962. Some of the material presented in this oration was published in the ROYAL SOCIETY OF HEALTH JOURNAL, 82:51 (March-April) 1962.

Type 1 vaccine protects against the virus that is the chief cause of epidemics and over the years has been responsible for about 85 per cent of poliomyelitic paralysis. During the winter and spring months, in populations with a low incidence of infection by the other enteric viruses, an antibody response of 100 per cent, or close to it, has been demonstrated for all three types of poliovirus in the United States, Britain, Switzerland, Czechoslovakia, Yugoslavia and South Africa — and this is of special importance for the immunization of infants between two and six months of age, in whom even potent killed virus vaccine is very often ineffective.

2. Extensive multiplication of the vaccine strains in the intestinal tract produces a local resistance to reinfection that is independent of the antibody in the blood. A critical evaluation of the available data indicates that even high levels of the antibody in the blood, either placentally transmitted or produced by killed virus vaccine, have no effect on the multiplication of polioviruses in the intestinal tract. This is a very important point to remember because it is basic for the formation of policy in the United States. If both the Salk and oral vaccines will be used haphazardly, we will never entirely eliminate poliomyelitis. For while the Salk vaccine, in adequate dosage, can produce immunity to paralysis, it leaves the intestinal tract a fertile place for the multiplication of the paralyzing viruses, which will continue to disseminate in the community, attacking those who were not immunized or have lost their immunity.
3. The third point of importance in the use of live poliovirus vaccine, is that some unvaccinated persons — both children and adults — become immune by contact with young vaccinated children, and during the course of the extensive community-wide programs, the incidence of such contact immunization has been especially high. Many experiences in the United States and elsewhere, where large numbers of susceptible, unvaccinated adults have been in contact with young children, who received all three types of the vaccine that I developed, have shown that this contact immunization is entirely safe.
4. Intestinal resistance in a large proportion of the child population, induced either by natural infection or by the administration of the oral vaccines, leads to a break in the chain of transmission of polioviruses which can eliminate the disease from the unvaccinated as well as from the vaccinated persons in a community. The important words here are "large proportion" and "child population," because the very young children are the most important spreaders of the polioviruses, and because the chain of transmission of naturally occurring polioviruses cannot be broken when a large proportion of the very young children have had only killed virus vaccine, without natural or oral-vaccine-induced infection of the intestinal tract. A critical analysis of the available field data in the United States as well as elsewhere provides no evidence that extensive use of killed poliovirus vaccine has prevented widespread dissemination of polioviruses when these are introduced in a community either naturally or artificially. If there was still any question whether naturally occurring polioviruses can spread extensively in a community in which the Salk vaccine has been used extensively, the answer was supplied last autumn in Syracuse, New York. This was an area where Salk vaccine had been used as extensively as anywhere in the United States — and yet a severe epidemic developed in August. The epidemic was brought to a halt only after about 400,000 people were quickly given the oral vaccine, but many people developed severe paralysis from infections acquired before the mass vaccination campaign.

The main disadvantages of the live, orally administered vaccine result from the interference phenomenon, either when certain naturally occurring enteric viruses are multiplying in the intestinal tract at the same time or when a mixture of all three types of the vaccine is given to persons who lack immunity for all three types. Among populations with a high incidence of infection with other enteric viruses throughout the year, as occurs in tropical countries, the rapid mass administration of poliovirus vaccine has been found to curtail temporarily the dissemination of the other viruses, and two doses of trivalent vaccine given at an interval of eight weeks or more may constitute an adequate procedure under these conditions. When oral vaccine is given during the summer time in temperate climates, as in the case of young infants who receive it as part of their regular immunization schedule, a subsequent dose of trivalent vaccine can make up for the potential interference. While the separate administration of the three types at suitable intervals is the best solution for the frequent inadequacy of the single dose of trivalent vaccine, tests by Smorodintsev et al., in the U.S.S.R. in 1959, by Skovranek and Zacek in Czechoslovakia in 1960, by Horstmann et al. in the U.S.A. in 1960 and 1961, and by Goffe and Schär in Switzerland, have shown that in young children a two-dose schedule, consisting of Type 1 followed by a mixture of

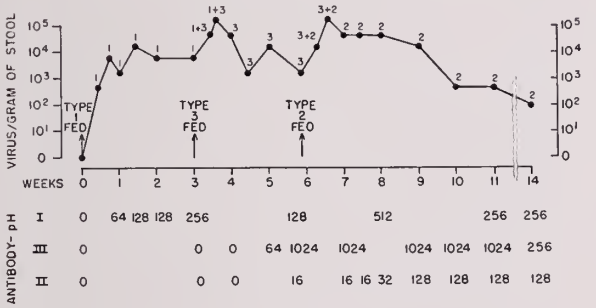
Types 2 and 3, has given serologic responses entirely comparable to those following the separate administration of the three types. Whether or not this modified, two-dose schedule produces equally good intestinal resistance for the Type 2 and Type 3 viruses remains to be determined.

Fig. 1

ONE PATTERN OF VIRUS MULTIPLICATION IN HUMAN ALIMENTARY TRACT WHEN 10^5 PLAQUE FORMING UNITS OF 3 IMMUNOLOGIC TYPES OF ATTENUATED POLIOVIRUS WERE FED AT 3-WEEK INTERVALS

Adult Volunteer without Antibody for any of 3 Types of Poliovirus

NUMBERS OVER DOTS INDICATE TYPES OF VIRUS BEING EXCRETED



(Reprinted from Sabin[3])

Figure 1 is shown here to illustrate the multiplication of the 3 types of virus and the development of antibody in an individual without immunity to any of the 3 types of poliovirus, when the vaccine strains were fed sequentially in the order of 1 - 3 - 2 at intervals of 3 weeks. Later studies suggested that longer intervals are more desirable for the production of a higher incidence of good intestinal resistance to reinfection. The Type 1 vaccine is fed first because over the years it has been responsible for about 85 per cent of paralytic poliomyelitis. The Type 3 vaccine is fed next, not only because it is next in importance as a cause of paralytic poliomyelitis — about 10 per cent over the years — but also because it may be easier to terminate a Type 3 infection by feeding Type 2 virus than vice versa, since after feeding a mixture of the Types 2 and 3 viruses, the Type 2 usually multiplied more readily in the intestinal tract.[5] It may be seen in Figure 1, how the Type 1 virus stops being excreted shortly after the Type 3 is administered, and Type 3 stops being excreted shortly after the Type 2 virus is administered. A similar situation has been observed in an entire community after the sequential feeding of the 3 types of vaccine in the order of 1 - 3 - 2, the circulation of the preceding type being suppressed by the feeding of the next type.[6] (See Tables 1 and 2.)

The development of antibody in 100 per cent of children, aged 3 months to 6 years, during the community-wide program in Cincinnati in 1960 is documented in Table 3. Comparable antibody responses in young children have been observed in New Haven, Conn.; Middletown, Conn.; Harrisburg, Pa.; Britain; Switzerland; Czechoslovakia; Yugoslavia, and South Africa.

The oral poliovirus vaccine now in use was ready for tests on increasingly larger numbers of human beings early in 1957. It was studied by many independent investigators in the U.S.A. and abroad, first on hundreds, then on thousands, ten thou-

continued on next page

TABLE 1.

Recovery of Polioviruses and other Enteric Viruses from Vaccinated Persons in Cincinnati 1 Month after Feeding Last of 3 Types of Poliovaccine in Order of I–III–II at Monthly Intervals

Rectal Swabs Collected July 20 — August 3, 1960

SPECIMENS OBTAINED BY	AGE GROUP YEARS	NUMBER TESTED	PER CENT POSITIVE				
			NON-POLIO	POLIO I	POLIO II	POLIO III	POLIO-TOTAL
CLINICS Mostly Lower Income Families	3/12-5	274	10	0	17	3	20
PRIVATE DOCTORS Mostly Higher Income Families	3/12-5	236	4	0	24	5	29
	6-16	41	0	0	22	7	29
	22-48	36	0	0	28	0	28
TOTAL	3/12-48	587	6	0	21	4	25

(Reprinted from Sabin et al.[6])

TABLE 2.

Recovery of Polioviruses and other Enteric Viruses from PRE-SCHOOL Children in Cincinnati Before and at Different Times After Community-Wide Use of Oral Poliovaccine

Dates Vaccine Given Type I - end April, Type III - end May, Type II - end June

RECTAL SWABS OBTAINED BY	DATE COLLECTED	TIME IN RELATION TO VACCINE	ORAL VACCINE GIVEN	NO TESTED	PER CENT POSITIVE	
					POLIO	NON-POLIO
CLINICS Mostly Lower Income Families	MID-APRIL	BEFORE	NONE	493	0.4 I	4.5
	MID-MAY	2-3 wks POST I	"	56	16 I	4
	END-JULY	1 month " II	I + III + II	274	20 II + III	10
	END-SEPT	3 mos " II	I + III + II	187	0	23
	" "	" " " II	NONE	268	0.7 II	21
PRIVATE DOCTORS Mostly Higher Income Families	MID-APRIL	BEFORE	NONE	507	0.2 I	2
	END-JULY	1 month POST II	I + III + II	236	29 II + III	4
	END-SEPT	3 mos " II	I + III + II	240	0	6
	" "	" " " II	NONE	263	0	10

(Reprinted from Sabin et al.[6])

TABLE 3.

ANTIBODY RESPONSE IN 3-MONTH TO 6-YEAR OLD CHILDREN RECEIVING LIVE, ORAL POLIO VACCINE DURING COMMUNITY-WIDE PROGRAM IN CINCINNATI

DOSAGE & SCHEDULE: TYPE 1 - 2×10^5 PFU — END OF APRIL, 1960
TYPE 3 - 1×10^5 PFU — END OF MAY, 1960
TYPE 2 - 3×10^5 PFU — END OF JUNE, 1960

TYPE	NO NEGATIVES TESTED	PER CENT CONVERTED TO POSITIVE	
		1:6 or more	1:3 or more
1	108	99.1	100
2	66	98.5	100
3	121	97.5	100

(Reprinted from Sabin et al.[6])

sands, hundreds of thousands, and finally on millions of people in the extensive field trials of 1959 in the U.S.S.R.

Since the completion of the extensive field trials in 1959, the oral vaccine has been used on an increasingly larger scale in 1960 and 1961 both for the attempted complete elimination of the disease and the rapid termination of epidemics. The prompt mass production of this vaccine which began in 1959 at the Institute for Poliomyelitis Research in Moscow, under the dynamic leadership of Professor M. P. Chumakov, has resulted in its greatest use in the U.S.S.R. and many of its allied countries, where more than 100 million persons have received many doses by the end of 1961. After a somewhat slower start this vaccine is now in production in the U.S.A., Canada, Britain, South Africa, Yugoslavia, Italy, Belgium, France, West Germany, and the People's Republic of China — and while precise figures are not immediately available, a total of more than 30 million persons in Japan, South Africa, Yugoslavia, U.S.A., Britain, Israel, India, Brazil, Chile and Switzerland received this vaccine for the first time in 1961. I should like to summarize here some of the information available to me at the end of 1961.

Community-wide Programs with Extensive Coverage of Child Population

I hope I may be forgiven for mentioning first my own city of Cincinnati, where a community-wide immunization of children, three months to 18 years of age, was first carried out in the spring of 1960. About 180,000 children received the oral poliovirus vaccines in 1960, and another 55,000 children, including the majority of those born since the 1960 program, received the three types of vaccine during the months of March to May of 1961. The results for 1960 have already been published in detail. Approximately 75 per cent of the children in the city proper with a total population of 500,000, and a smaller proportion of the children in the surrounding suburbs with a population of about 360,000, have received the vaccine, and careful surveillance indicated that not a single case of paralysis due to polioviruses of local origin has occurred in this entire population in 1960 and 1961. This is especially noteworthy, since with the exception of a few thousand people, the adults have not received the oral vaccine and a very large proportion of them, especially among the young fathers, have had little or no Salk vaccine.

Careful clinical and virologic surveillance has also been carried out in Czechoslovakia, a country with a total population of about 13.6 million, where more than 90 per cent of the children from two months to 15 years of age first received oral vaccine in the spring of 1960 and again in 1961. Here also there has not been a single confirmed case of paralysis due to polioviruses of local origin since July 1960. This does not mean that there have not been reports of sporadic cases of facial or other palsies, but as in Cincinnati careful clinical and virologic studies have shown that these were not caused by polioviruses. Comparable results have also been obtained in Hungary in 1960 and 1961.

The U.S.S.R., which includes many countries, different climates, and different population groups, has given multiple doses of oral vaccine since early 1960 to almost the entire population under 21 years of age. However, the official statistics on reported cases of so-called poliomyelitis do not provide a satisfactory basis for evaluating the effect of these repeated vaccine feedings (see Figure 2). The residual reported cases, small in number, are distributed almost equally throughout the year. In many areas of the U.S.S.R. where virologic and epidemiologic laboratories have carried out studies on reported cases, it was found that the majority were clinically atypical with rapid disappearance of weakness or paralysis, and that even in the few cases of persistent paralysis it has either not been possible to establish a poliovirus etiology or concurrent infection was demonstrable with other viruses capable of producing paralytic manifestations in human beings. On the basis of personal comparative observations, I do not think that the poliomyelitis situation in the U.S.S.R. is now different from that obtaining in Czechoslovakia or Cincinnati, except that in the U.S.S.R. the Ministry of Health continues to report cases as poliomyelitis, that actually are not poliomyelitis on either clinical or etiologic grounds. While the diagnostic problems, particularly in large countries, are not simple, it is obvious that one cannot base any judgment on

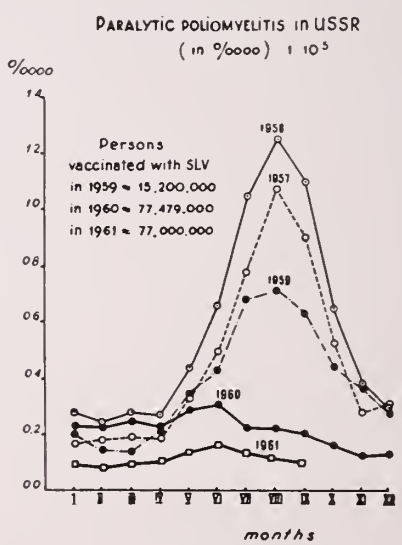


FIGURE 2

Graph prepared by Professor M. P. Chumakov, Institute for Poliomyelitis Research, Moscow, U.S.S.R.

the kind of program that is required for the complete elimination of poliomyelitis on unconfirmed clinical reports of poliomyelitis.

Another striking example of the rapidity with which poliomyelitis can be rapidly and seemingly completely eliminated from a large population, is provided by East Germany with a total population of about 17.5 million. Oral poliovirus vaccine was first given to about 80 per cent of those under 21 years of age in 1960 — Type 1 in April and May and a mixture of Types 2 and 3 in June. Three paralytic cases, which occurred in vaccinated persons shortly after administration of the Type 1 vaccine were shown to have been caused by Type 3 virus. Only a few sporadic cases, not all confirmed, occurred after the end of July, 1960. In 1961, a dose of trivalent oral vaccine was given to all those who received vaccine in 1960, and vaccine was also given to the children born since the 1960 campaign as well as those under 21 years, who did not previously receive it. Type 1 vaccine candy was offered on a voluntary basis to persons between 21 and 40 years of age. Altogether 7.5 million persons swallowed some poliovirus vaccine. According to a report by Doctors Th. Kima and W. Belian at the September meeting of the European Association Against Poliomyelitis and a letter that I received from Doctor Belian in December, not a single confirmed case of poliomyelitis occurred in the entire population in 1961 (see Figure 3). Three clinically and virologically confirmed cases occurred in visiting relatives shortly after their arrival from West Germany, where more than 3,800 cases, with few exceptions all paralytic, had been reported by the end of October, 1961, for a population of about 54 million. I understand that extensive community-wide immunization programs with oral poliovirus vaccine, are being carried out in West Germany at this time.

Locally produced vaccine was used for nation-wide campaigns in advance of the 1961 poliomyelitis season in the Union of South Africa and Yugoslavia.

In Yugoslavia the three types of vaccine were given separately in the order of 1 - 3 - 2. I have a report only for Serbia with a total population of about 7.5 million people, where, according to communications from Doctors Stojkovic and Milovanovic, there were no complications during the period of vaccination, and the small number of cases reported subsequently were not confirmed as poliomyelitis either clinically or virologically, with the possible exception of a single unvaccinated case, which yielded Type 2 poliovirus in September, that still needs to be investigated.

In the Republic of South Africa, the Ministry of Health organized four mass feedings of oral poliovirus vaccine, including African children up to the age of ten, Indian and colored children up to school-leaving age of ±16, and Europeans up to age 30, except for recently arrived immigrants from Northwest Europe and North America, who were entitled to receive vaccine up to age 40 years. The first feeding at the end of October and early November 1960 consisted only of Type 1 vaccine and was restricted to the larger cities and towns. Triple vaccine was used for the subsequent three feedings in the entire country in May, July and September 1961.

Although the total estimated number of persons in the selected, susceptible age groups was 6.25 million, a larger number actually received the vaccine, because in some districts many older persons turned up for the vaccine. In most districts the response was from 90 to 100 per cent, and only in a few (predominantly in Natal) was the coverage only 50 to 70 per cent. The nine cases of poliomyelitis that appeared shortly after vaccination either turned out to be of another type (for example, Type 2 or Type 3 after administration of Type 1 vaccine) or occurred so soon after ingestion of the vaccine that it was apparent that the vaccine was given during the incubation period of a naturally acquired infection. Since the completion of the campaign there have been only six reported cases of paralytic poliomyelitis in the whole Republic of South Africa — two of them from Cape Province and four from Natal, where the response to vaccination in some districts was not as good as in the remainder of the country. Moreover, five of these cases occurred in children who received no vaccine, and one in a child who received only one dose. "In Johannesburg, which in all previous years would have had several scores of cases of paralytic poliomyelitis by this time of the summer, there have been no cases admitted to the Fever Hospital since June." (Personal communication from Doctor James H. S. Gear on 27 January 1962.)*

Since the end of 1961, millions of persons have received oral poliovirus vaccines for the first time in extensive community-wide programs in Austria, Switzerland, West Germany, Brazil, Chile, Mexico, Ceylon — and in the U.S.A. and Canada especially since the spring of 1962.

*In a letter dated 25 June, 1962, Dr. P. D. Winter of The Poliomyelitis Research Foundation in Johannesburg wrote that serological tests on about 2,000 blood specimens indicated "a virtual 100%" immune response in children, that in the Johannesburg-Witwatersrand area there have been no cases of paralytic poliomyelitis for over a year, and that "the tentative figure of notified 'poliomyelitis' cases for the Republic and South West Africa for the period of October 1961 to May 1962 is 48. None of these received vaccine and in six cases only were virus isolations made."

continued on next page

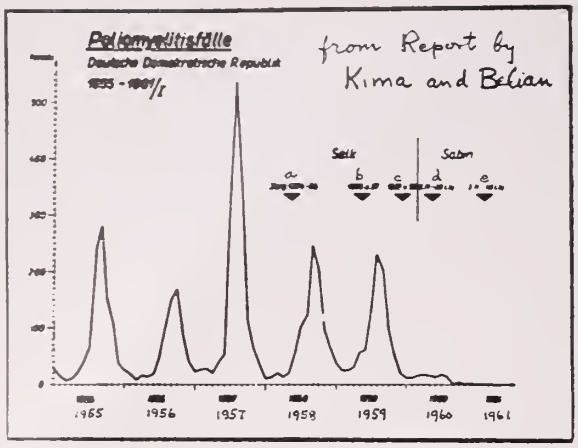


FIGURE 3

Reproduced from *National Report of Immunization Program of German Democratic Republic* by Th. Kima and W. Belian in 1961 Proceedings of European Association Against Poliomyelitis. a = born 1954-1956; b = born 1953 and 1957; c = born 1952 and 1958; d = 3 months–20 years; e = 3 months–40 years.

Innocuity of Spread of Vaccine Strains to Children and Adults Where Only Part of the Population Had Been Vaccinated

In 1960 and 1961, the three types of oral vaccine that I developed were administered during the winter, spring and summer, under conditions in which large numbers of unvaccinated older children and adults were in contact with vaccinated preschool and schoolchildren in many American cities without any evidence of harmful effects. This happened in Cincinnati, O.; Rochester, N. Y.; Middletown, Conn.; Harrisburg, Pa.; Cumberland, Md.; Brookline, Mass., and Atlanta, Ga. It is noteworthy that in Rochester, N. Y., and in Atlanta, Ga., the Type 3 vaccine was administered in June to about 400,000 children, and it undoubtedly continued its spread in the community during the subsequent summer months, but without any evidence of harmful effects. In these cities, as in most of the U.S.A., a large proportion of the parents, particularly the fathers, had received little or no killed virus vaccine. Thus, the concern expressed by some members of the W.H.O. Expert Committee in June 1960, about the use of oral vaccine in countries where over 20 per cent of poliomyelitis cases occur in persons over 15 years of age, has found no support in the subsequent experiences in the U.S.A.

Use of Oral Vaccine Under Epidemic Conditions

It is, of course, better to prevent epidemics than to attempt to stop them after large numbers have already developed the disease and many others are being infected, or are already infected and in the incubation period. It is evident that the vaccine can have no effect on those who are already infected, and that paralytic cases must therefore be expected to occur among those receiving the vaccine for a period corresponding to the incubation period for paralysis, which in man is believed to have a range of 8 to 36 days, with an average of 17 days.

In 1960, after the field trials had already shown that each of the three types of this vaccine was harmless under non-epidemic conditions, Type 1 vaccine was used for the first time in an attempt to abort predominantly Type 1 epidemics — and this was done in Belgrade and several other cities in Serbia. It should be pointed out that here also the vaccine was, in most instances, given over a period of several weeks, instead of a few days, and in most instances reached only a fraction of the susceptible child population. Despite these deficiencies there was evidence that the epidemics were aborted much more quickly and completely than ever before and during months of the year when epidemics ordinarily continue or increase in intensity.

In 1961, oral vaccine was used in an attempt to stop epidemics in chronological order in the following places: India, Israel, Atlanta, Ga., Japan, three counties in New York State, Newberry County, South Carolina, Hull, England, and Santiago, Chile. Almost 14 million persons received the vaccine — about 700,000 in the U.S.A. and about 12 million in Japan.

In Israel, despite extensive use of very potent, killed virus vaccine, a Type 1 epidemic began to develop early in 1961 after two years of very low incidence. By the end of May there were already 140 cases, almost entirely in young babies. From 30 May to the end of June, Type 1 oral vaccine was given during periods of about a week in different regions, to about 236,000 children from 4 days to 4½ years of age — 96 per cent of all Jewish and Arab children of this age in Israel. Although cases of poliomyelitis continued to occur after initiation of this program, the epidemic was rapidly aborted at a time of the year when it would have been expected to increase in intensity.

In Atlanta, Ga., there was fear of an impending Type 3 epidemic, because by 12 June there were already four paralytic cases of this type, and virologic studies by Doctor H. Gelfand and his associates on healthy children in one part of the city showed an extraordinarily high incidence of carriers of Type 3 poliovirus. Type 3 oral vaccine was given to 274,000 children from 3 months to 15 years of age between June 22 and 27, representing 80 to 85 per cent of the children in this age group. About 75 per cent of the total amount of vaccine was given in the first two days. During the period of vaccine administration an additional three Type 3 paralytic cases occurred — all of them in vaccinated children with onsets ranging from two days before to three and six days after ingestion of oral vaccine. In July there were two Type 3 cases in unvaccinated children and two other cases of persisting paralysis in unvaccinated persons from whom no

virus could be recovered despite repeated tests on many specimens. From the beginning of August to the end of the year, not a single paralytic case occurred in the entire area with a total population of about one million people. While wondering whether this really represented the complete abortion of a developing Type 3 epidemic in Atlanta by inundating the child population with the Type 3 vaccine strain, one recalled that in 1960 Baltimore after a similar beginning ended the year with about 100 cases of Type 3 poliomyelitis, despite extensive use of killed virus vaccine in an attempt to stop the epidemic.

An epidemic of Type 1 poliomyelitis began to develop in August in three counties of New York State, where Salk vaccine had been used about as extensively as anywhere in the U.S.A. By the end of August when the weekly number of cases continued to mount, Type 1 oral vaccine was given to approximately 400,000 children and adults. Doctor Harry Feldman carried out extensive clinical, epidemiologic, and virologic studies in Syracuse and surrounding Onondaga county with a total population of 423,000, and my information is based on data he transmitted to me. There were 25 cases with onset of paralytic poliomyelitis before the oral vaccine program began on 29 August and continued on a massive scale for three days. During this period there were an additional five cases, four of them in orally vaccinated. During the first six days of September, i.e., immediately after the mass vaccination, there were 11 paralytic cases (nine of them in vaccinated), and during the next nine days there were eight additional cases (five of them in vaccinated) — and after that until the end of the year, not a single case of confirmed poliomyelitis. There were a few subsequent reported cases in adults which turned out to be bursitis or slipped intervertebral disc, or Coxsackie B 5 infection with isolation of virus from the cerebrospinal fluid. Thus, this epidemic was over within 15 days after a massive three-day campaign with oral vaccine.

Japan had its biggest poliomyelitis epidemic in 1960 with a total of about 5,600 reported cases. Despite extensive use of Salk vaccine early in 1961, another epidemic began in the southern part of the country in May, and by early June there were already more than 1,400 cases with many deaths in various parts of Japan. Type 1 poliovirus was predominant. At the end of June and early July several hundred thousand children received Type 1 oral vaccine in the southern part of the country, and beginning with the last week in July, about 12 million children received trivalent, oral vaccine in a rapid, extraordinarily well-organized national campaign. There was a rapid, marked and seasonally unprecedented drop in the number of reported cases.

The fact that a similar pattern has followed the large-scale use of oral poliovirus vaccine in the face of many different epidemics in different parts of the world, can now leave little doubt of a cause and effect relationship. On the basis of available data the following points seem to be of greatest importance in the face of an epidemic:

1) start early — do not wait until the epidemic is full-blown;
2) give the oral vaccine as quickly as possible, within a few days and not weeks, to the maximum possible number of potential susceptibles, but especially the young children.

Present State of Poliomyelitis in Different Parts of the World

In some parts of the world poliomyelitis has already been completely or almost completely eliminated by mass use of oral poliovirus vaccine. In other parts, where Salk vaccine has been used, but not extensively, poliomyelitis has continued to be a serious problem — in Europe this applies especially to West Germany, France and Italy. In 1960, West Germany had about 3,800 cases, and in 1961 a somewhat larger number. France, which for years has had a low endemic rate — the annually reported cases for 1951 to 1955 varied from 1,493 to 1,834, with a total of 8,160 for these 5 years — has actually had more poliomyelitis since the advent of killed virus vaccine, with a total of 11,132 cases during the 5 years of 1956 to 1960, with 2 high years of 4,109 and 2,564 in 1957 and 1959 respectively. Italy reported 23,895 cases during the 5 years of 1956 to 1960, with 8,198 cases in 1958, and more than 3,000 up to the end of October 1961.

In recent years poliomyelitis has begun to emerge as an epidemic disease of considerable importance in many countries of Asia, Africa and South America, where in the past the infection rate was high and the disease rate low, just as it was in Northern Europe and North America only 40 to 50 years ago. The epidemics in Japan have already been mentioned, and during recent poliomyelitis conferences in Moscow there were reports of extensive epidemics on the mainland of China and in North Viet Nam. Thus, North Viet Nam with a total population of only 16 million in 1959 had an epidemic of 6,198 reported cases, and 20 strains of poliovirus that were isolated during the epidemic were all reported to be Type 2. Extensive Type 2 epidemics were also reported in China in 1959. A Type 2 epidemic also occurred in Nicaragua in 1958.

In the United States, Canada and similar countries, where Salk vaccine has been extensively used since 1955, the incidence of paralytic poliomyelitis has been decreasing over the years, but not without epidemic upsurges. Thus in 1959, there were about

continued on next page

6,200 cases of the paralytic disease in the U.S.A. and 1,850 in Canada, which has a population of only about 18 million. The very low incidence of poliomyelitis in the U.S.A. and Canada in 1961 has been interpreted by some as evidence that the killed virus vaccine was breaking the chain of transmission of polioviruses, and has led to predictions that poliomyelitis will disappear without any new mass campaigns of immunization. However, it is well known that years of high poliomyelitis incidence, such as occurred in 1959, are followed by years of low incidence until enough children with susceptible intestinal tracts have been added to the population again to permit the extensive spread of epidemic Type 1 strains. In the pre-vaccine era, it was shown that the Type 1 virus was less common and the other types more common as a cause of paralytic disease during the years following large epidemics — a phenomenon which is now being interpreted by some people as indicating that more extensive use of killed virus vaccine is eliminating Type 1 virus from circulation. As a matter of fact several years of very low incidence must serve as a danger signal for future epidemics, if the immune status of the population is not maintained. Serologic surveys, such as have recently been carried out in New Haven and Middletown, Conn., and in Cincinnati, O., prior to the use of oral vaccine, have indicated that among the younger children under two years of age the proportion without Type 1 antibody is high even among those who have had three doses of Salk vaccine of recent manufacture. This is the background of current deliberations in the U.S.A. and certain other countries about the procedures to be used for the elimination of the disease.

Considerations Regarding Optimum Use of Oral Poliovirus Vaccine

In countries where relatively little or no killed virus vaccine has been used until now, there would be little if any disagreement that a suitable program for the elimination of the disease should consist first of a community-wide oral vaccine program for the susceptible age groups to be followed by a maintenance program in which the newly-born children receive the vaccine during the first six months of life. There are many who are convinced that a similar program is indicated in the countries in which the extensive use of Salk vaccine has markedly diminished but not eliminated the paralytic disease. In such countries it is important that all young children receive the oral vaccine, regardless of how many doses of Salk vaccine they may have had. This is necessary not only from a public-health point of view for breaking the chain of transmission of polioviruses and thus protect also those in the family and others in the community, who remain unvaccinated, but also from the point of view of the individual child who either still lacks immunity for one or more types — as the serologic surveys have indicated — or will benefit from the booster effect. This type of program was recommended in June 1961, by the American Medical Association after careful study of the question by a specially appointed committee, and also on February 17, 1962, by Subcommittee One of the U.S.P.H.S. surgeon general's Advisory Committee on Poliomyelitis Control.

There are others who believe that poliomyelitis is coming under control regardless of which method of immunization is chosen, and that the present situation in the U.S.A. does not warrant reversal of previous policies or new mass campaigns with oral vaccine for the millions who have already had Salk vaccine. The recommendation that either the oral or the killed poliovirus vaccines be used for immunization of infants or other hitherto unvaccinated persons, the choice being left to the individual physician or health officer, will immunize many persons but will not eliminate poliomyelitis. The same people who make the above recommendations, because they disregard the basic difference in the properties of the two vaccines, suggest that the main indication for the mass use of oral vaccine is in the control of epidemics. Since there is now abundant evidence that epidemics of poliomyelitis need never occur, it seems highly desirable to take the necessary measures to prevent them rather than recommend procedures for stopping them after many needless cases of paralysis and death have occurred.

Many American state and city health officers rightfully envisage great difficulties when they contemplate community-wide, oral poliovirus vaccine programs by procedures to which they are accustomed. They have limited budgets, personnel, and clinics for a variety of public health problems and one can understand why they may give poliomyelitis a low priority. For this reason, it is most heartening to see the extraordinary success that has been achieved by a new method developed and implemented by county medical societies in response to the June, 1961, recommendation of the Council of the American Medical Association that they assume the leadership in carrying out community-wide oral poliovirus vaccine programs. This new method was first developed by Doctor Richard B. Johns of the Maricopa County Medical Society in Phoenix, Arizona, in close co-operation with Doctor S. F. Farnsworth, director of the county health department, and put in operation January 14, 1962. The basic principles of this method are:

1. The county medical society carries out the program as a community service, together with the health department or alone if necessary, and assumes the financial responsibility for the cost of the vaccine and those incidental

expenses for services that cannot be performed by volunteers.

2. The medical society arranges for an intensive program of public information, and recruits and organizes the necessary volunteers for the various activities connected with the distribution and administration of the vaccine. These volunteers include not only physicians, pharmacists and nurses, but also others from various civic organizations such as parent-teachers' organizations, Red Cross, National Foundation chapters, boy scouts, amateur radio operators, and similar groups.
3. Two Sundays are set aside for the administration of each type of vaccine, to make it possible for families to come as a unit to the vaccination centers. The vaccine is given to young and old not only to immunize the adults, but also because it is an effective means for reaching the maximum number of preschool children.
4. The vaccination centers are set up in schools throughout the city and county so that people can obtain the vaccine in their own neighborhoods, without having to travel great distances.
5. The people are invited to make a voluntary contribution of 25 cents or more per dose of vaccine as they leave the vaccination center, none being asked to contribute prior to receiving the vaccine.

The voluntary response to this program has been beyond all expectations, particularly since it was a response to a challenge for the hoped for complete elimination of poliomyelitis in the future rather than under the impact of an existing epidemic. About 80 per cent or more of the total population, and higher proportions of preschool and schoolchildren, have turned out to receive the vaccine — not only for the first type, but also for the subsequent types which were given at 6-week intervals. So many people contributed more than the suggested 25 cents per dose, that the medical society had large sums of money left over that are expected to be used for some other needed community public health activity.

This program was then quickly repeated with improvements and modifications in Tucson, Arizona, under the able leadership of Doctor Hugh C. Thompson of the Pima County medical society and Doctor Frederick J. Brady, the director of the county health department, and numerous communities throughout the U.S.A. began to use the Arizona method.

[Subsequent to delivery of this lecture, some extraordinary accomplishments have been reported from several large population centers — notably in the Cleveland, Ohio, area where more than 1.5 million people, or about 94 per cent of the total population, received the vaccine on two consecutive Sundays, and in Omaha, Nebraska, where the whole community, about 315,000 people (85 per cent of the entire population) was vaccinated on a single Sunday afternoon, and in both of these places, the response was equally good for the next type given 4 weeks later. See below.]

The future prospects for the complete elimination of poliomyelitis from the U.S.A. will depend on the extent to which the Arizona-type, community-wide programs are carried out throughout the entire country, and on how the oncoming generations of children will be immunized. It is important that, after completion of a community-wide program, the new generations of children receive the oral poliovirus vaccines along with their other immunizations as part of an improved total program of infant immunization in the United States, carried out by the local medical profession and the community health services. The February 17, 1962, report of Subcommittee One of the U.S.P.H.S. surgeon general's Advisory Committee on Poliomyelitis Control recommended the following schedule, which fits in well with current practices in the United States for the immunization of infants with diphtheria-pertussis-tetanus and smallpox that can be given concurrently with the oral vaccine.

APPROXIMATE AGE	ORAL POLIOVIRUS VACCINE
6 weeks	Type 1
3 months	" 3
4½ months	" 2
10-12 months	Mixture of 1, 2 and 3

The committee pointed out that "although 6 weeks is the recommended age for beginning the program, it may be started later, using the same six-week intervals for the first three doses." The booster dose of trivalent vaccine is recommended for the infants, to make up for any possible interference with adequate immunization when the first doses are administered during the summer time or during a period of breast feeding.

It must be pointed out that if a sufficiently large proportion of infants are not vaccinated, as is the case now in many parts of the U.S.A., or receive only Salk vaccine, there will soon accumulate a large enough population without intestinal resistance to the polioviruses to permit circulation of paralyzing polioviruses that may be introduced from without, and thus again endanger those who have never acquired immunity or lost it. We are only at the very beginning of our attempts to eradicate poliomyelitis, and ultimate success, as in the eradication of smallpox, will depend on continuing effort and vigilance.

concluded on next page

Addendum

By early August, 1962 about 19 million persons had received Type 1 vaccine, 13 million the Type 3 vaccine, and 6 million the Type 2 vaccine in various community programs throughout the United States, and many more such programs are already scheduled for the forthcoming autumn and winter months.

References

[1]Paul, J. R.: The Eighteenth Charles Value Chapin Oration. Chapin and Modern Epidemiology, Rhode Island M.J. 42:375, 1959

[2]Enders, J. F.: The Fourteenth Chapin Oration. Growth of Poliomyelitis Virus in Tissue Cultures: Applications to Diagnosis and Prevention of Poliomyelitis. 1955. Unpublished

[3]Sabin, A. B.: Present Status of Attenuated Live-Virus Poliomyelitis Vaccine, J.A.M.A. 162:1589, Dec. 29, 1956

[4]Sabin, A. B.: Properties and Behavior of Orally Administered Attenuated Poliovirus Vaccine, J.A.M.A. 164: 1216, July 13, 1957

[5]Sabin, A. B.: Royal Soc. Health J. 82:51, 1962

[6]Sabin, A. B.: In *First International Conference on Live Poliovirus Vaccines*, Scientific Publication No. 44, Pan American Sanitary Bureau, Washington, D.C., 1959

[7]Sabin, A. B., et al.: Community-wide Use of Oral Poliovirus Vaccine. Effectiveness of the Cincinnati Program, Am. J. Dis. Child. 101:546, 1961

See References 5 and 7 for fuller bibliography.

15th ANNUAL

DR. ISAAC GERBER ORATION

Sponsored by the Miriam Hospital Staff Association

WEDNESDAY . . . . . OCTOBER 24, 1962, at 8:30 P.M.

At the Auditorium of the Miriam Hospital

Oration: "PULMONARY EMBOLISM — A ROENTGEN-CLINICAL SURVEY"

FELIX G. FLEISCHNER, M.D.

Formerly Chief Radiologist, Beth Israel Hospital
Boston, Massachusetts

Obstetrician-gynecologist wanted as associate for board certified ob-gyn. man in twelve doctor specialty group; salary minimum $14,000, early partnership; excellent clinical and hospital facilities; community of 14,000; fine schools; year round recreation includes hunting, fishing, boating, skiing, etc. Contact:

H. B. COPE, M.D.

Lenont-Peterson Clinic Virginia, Minnesota

J. E. BRENNAN & COMPANY

Leo C. Clark, Jr., B.S., Reg. Pharm.

Apothecaries

Two Convenient Locations

5 North Union Street Pawtucket, R. I.

140 Central Avenue Seekonk, Mass.

7 Registered Pharmacists

Pharmacy License #226

THE SURGICAL TREATMENT OF STENOSIS AND THROMBOSIS OF THE EXTRACRANIAL PORTIONS OF THE CAROTID ARTERIES*

CHARLES ROB, M.D.

The Author. *Charles Rob, M.D., of Rochester, New York. Chairman, Department of Surgery, University of Rochester School of Medicine; President, International Cardiovascular Society; Late Professor of Surgery, University of London, England, and Director of the Surgical Unit, St. Mary's Hospital, London.*

THROMBOSIS of the internal carotid artery was noted by Penzoldt in 1881 and was well known to Gowers (1888) who discussed the effects of occlusion of both the internal carotid and external carotid arteries in his textbook, DISEASES OF THE NERVOUS SYSTEM. The majority of occlusions of the carotid arteries are due to atherosclerosis and occur outside the skull. To quote Hutchinson and Yates (1956 and 1957): "A surprising severity of disease of the extracranial in contrast to the intracranial cerebral arteries was noted in many patients." This is the important fact because the extracranial portions of the cerebral arteries are readily accessible to surgery. It appears that in about twenty per cent of patients who suffer an apoplectic stroke the cause is an occlusion of one or more of these extracranial cerebral arteries. In this connection Bull, Marshall, and Shaw (1960) studied eighty consecutive patients admitted as emergencies with an acute apoplectic stroke to the National Hospital for Nervous Diseases in London; in 17.5 per cent the cause was an occlusion of the cervical portion of an internal carotid artery. In each of these patients the diagnosis was confirmed by arteriography, and as vertebral arteriography was not carried out it is possible that occlusions of this vessel would have increased the incidence of occlusion of the extracranial cerebral arteries in this series.

In a series of 431 of our patients with proved stenosis or thrombosis of the extracranial cerebral arteries seen during the period 1954 to 1961, the cause was atherosclerosis in all but one patient.

Clinical Picture

It is important to realize that the typical and easily diagnosable neurological picture of internal carotid arterial occlusion is rare. This typical picture consists of a hemiplegia with blindness of the opposite eye, the paralysis being persistent if the thrombosis is complete and transient with further repeated and similar episodes if the vessel is stenosed but not completely thrombosed.

The recognition that a carotid arterial stenosis can produce transient episodes of paralysis sensory disturbance or blindness is of importance. In many patients who develop a complete hemiplegia the presence of these transient episodes before the complete occlusion should enable a correct diagnosis of carotid stenosis to be made. At this time effective surgical correction of the stenosis can prevent the development of a permanent hemiplegia. A study of our patients shows that more than 50 per cent of those with a complete major hemiplegia had suffered from such transient prodromal attacks.

Table 1 lists the various symptoms which stenosis or thrombosis of an internal carotid artery has caused in our patients. Patients with both stenosis and thrombosis of the internal carotid artery have been included because it has been impossible on many occasions to distinguish on clinical grounds alone between these two lesions. It is also possible

continued on next page

TABLE 1
Presentation in 200 Patients with Occlusion of the Internal Carotid Artery

		Number of Patients
Motor Symptoms		171
Upper and Lower Limbs	111	
Upper Limb Only	47	
Lower Limb Only	11	
Sensory Symptoms		91
Speech Difficulties		44
Visual Disturbances		41
Loss of Consciousness		32
Headache		30
Vomiting		14
Bruit Heard by Patient		10
Deafness		9
Severe Mental Changes		9
Convulsions		8
Dysphagia		6
Tenderness in the Neck		2
Respiratory Difficulties		2

*Presented at the Sesquicentennial Meeting of the Rhode Island Medical Society, at Providence, Rhode Island, May 8, 1962.

for patients to have a severe degree of stenosis or even a complete occlusion without developing any symptoms at all, the collateral circulation being adequate.

Of the various physical signs one, a murmur on auscultation, deserves special mention. With experience and by combining the findings at auscultation with other evidence obtained at a full clinical examination, it is often possible to make an accurate assessment of the state of the arterial tree without the aid of an arteriogram (Peart and Rob, 1960). In every patient in this series the course of the carotid and vertebral arteries in the neck has been examined in this way. Of the 206 patients with involvement of the internal carotid artery in the neck 34 had a complete occlusion and in no patient in this group was there a murmur on auscultation. Of the 172 patients with a partial occlusion or stenosis of this artery 77 patients or 44.9 per cent had a systolic murmur.

The Production of Transient Attacks

Transient attacks of carotid arterial insufficiency are uncommon after a complete occlusion but are a frequent forerunner of such a disaster. These attacks are usually seen in patients with an arterial stenosis. It appears that there are six main ways in which these attacks may develop. The first and probably the most important is that a reduction in the cardiac output, or blood pressure, or some similar change in the patient's general condition may cause a reduction in blood flow through an already narrowed artery. We have seen such attacks develop for a variety of causes including hemorrhage, coronary thrombosis, taking vasodilatior drugs, and episodes of paroxysmal tachycardia. The second is the accumulation of blood clot on the surface of a plaque of atheroma which still further narrows an already narrowed lumen. The third is the development of a complete occlusion which usually follows a period of gradually increasing arterial stenosis which may or may not have caused symptoms. A complete occlusion frequently causes severe and permanent changes and sometimes death, but at the other extreme a complete occlusion may on rare occasions cause no symptoms at all. In between these extremes lies a large group of patients who recover to a varying degree. The fourth cause is for hemorrhage to occur behind a plaque of atheroma; on six occasions we have operated when a patient who has suffered a major attack with partial recovery and at operation found a plaque of atheroma which has been raised like a flap by a small hemorrhage behind the plaque. The fifth is the production of distal emboli. Two types of arterial emboli will be considered: first the conventional embolus of blood clot and second multiple small emboli possibly of fibrin. In the case of the conventional embolus it is difficult to imagine how repeated transient attacks could be produced in this way. For this to occur the embolus would have to pass up the internal carotid artery, obstruct one of its branches, then break up and pass on so that the vessel could recanalize and then a day or two later when the next attack occurred the same thing would have to happen and so on. On the other hand the idea that these transient attacks might be caused by multiple fibrin emboli is attractive

Surgical Treatment

Occlusions of the cervical portions of the carotid arteries may be partial or complete. Ideally operation should be performed at the stage of arterial stenosis, and with increasing experience the diagnosis can be made at this stage in many patients. The operative reconstruction of the stenosed internal carotid artery is not a difficult operation for a vascular surgeon and the result should be satisfactory in nearly every patient. Since 1954 (Eastcott, Pickering, and Rob) we have operated upon 431 patients with a stenosis or thrombosis of the internal carotid artery and in 362 were able to establish a good blood flow. 227 of these patients were asymptomatic after the operation and 110 obtained objective improvement (Table 2). On the other hand as Table 3 shows, of 114 patients with a complete occlusion in only 59 was a good flow established and in only 29 of these was the patient rendered asymptomatic by the procedure.

Operations for Carotid Stenosis

The best procedure for a lesion of this type is a thromboendarterectomy (Rob and Wheeler 1957) and we were able to perform such an operation in 144 of our patients with a stenosis of the internal carotid artery. The next best procedure is for the surgeon to excise the narrowed segment of artery and restore continuity by a direct end-to-end anas-

TABLE 2

Results of Arterial Reconstruction Operation in 431 Patients by Type of Stroke

Type of Stroke	No. of Patients	Good Flow Established	Post-operative Course			
			Asymptomatic	Objectively Better	No Change	Died
Incipient or Transient	294	284	195	66	32	1
Progressing	64	36	15	12	29	8
Completed	73	42	17	32	20	4

TABLE 3

Results of Arterial Reconstruction Operations in 407 Patients with Stenosis or Thrombosis of the Internal Carotid Artery

Type of Occlusion	No. of Patients	Good Flow Established	Post-operative Course			
			Asymptomatic	Objectively Better	No Change	Died
Partial	293	286	182	62	46	3
Complete	114	59	29	39	37	9

tomosis. Only when these are not possible do we use an arterial substitute; of the various possible arterial substitutes, autogenous vein grafts are satisfactory in this situation. It is usually possible to establish a good flow. The four patients in whom this was not possible all had multiple plaques of atheroma which extended up into the intracranial portion of this vessel.

Where the occlusion is partial it is wise to inspect the brain for the possible ill effects of ischemia during the period of carotid occlusion; such protection is most needed when the occlusion is complete because the only patent vessel to be clamped will be the external carotid artery. Protection may be provided by hypothermia to 30° centigrade, the use of a temporary bypass, or perfusion of the distal arterial tree with oxygenated blood. Each method has its place. Probably as safe a procedure as any is to operate under local anesthesia. If no neurological symptoms develop, then all is well; if the patient begins to experience any adverse effects, then the distal arterial tree can be prepared with oxygenated blood or a temporary shunt of nylon inserted.

The carotid bifurcation may be exposed through a curved cervical incision which is centered over the artery and follows the line of the skin creases of the neck. After division of platysma muscle the facial vein will be seen. This should be divided and the common internal and external carotid arteries exposed. At this stage it is important to identify the twelfth cranial nerve. The surgeon now examines the carotid arteries and locates by both inspection and palpation the extent of the stenosis whether it is partial or complete and whether the internal carotid artery distal to the occlusion is patent or not. The usual procedure is a thromboendarterectomy. This is performed by opening the artery over the region of the stenosis and the development of a plane of cleavage in the media. The intima, any plaques of atheroma, the inner portion of the media, and the internal elastic lamina are removed, and the arteriotomy incision closed with a continuous suture of fine silk. In this situation the operation of thromboendarterectomy is usually successful. The reasons for this are many but the most important are that the area of arteriosclerosis is well localized and that the vessel distal to the occlusion has a nearly normal wall. This means that there will be a good outflow from the zone of arterial reconstruction with the result that recurrent thrombosis is uncommon.

The Mechanism of Recovery of Neurological Function

All physicians know that a patient can develop a fairly severe neurological deficit and recover completely, or nearly completely, presumably as the collateral circulation improves and with it the blood supply to the apparently paralyzed cerebral cells. In those patients one assumes that the cerebral cells are not functioning because of ischemia, but none the less they are alive because they recover. This means that ischemia can paralyze a cerebral cell, but in some patients these paralyzed cells do not die because they get just sufficient blood supply to enable them to live, though not to function. We know of no other explanation of this observed phenomenon of recovery from a stroke under a regime of either medical or surgical treatment.

Selection for Surgery

The operation for carotid stenosis is primarily prophylactic to prevent transient symptoms from becoming permanent and to prevent permanent symptoms from worsening. The operation for a complete thrombosis to be curative must be performed before the cerebral cells have died. For the success of this procedure it is necessary to introduce a sense of urgency into the management of patients with acute apoplectic strokes. It is useless to refer a patient for surgery months after a complete occlusion when major permanent neurological changes have occurred.

The Future

In the case of atherosclerosis of the extracranial cerebral arteries two main lines of development are likely to occur. The first concerns the surgery of partial occlusions, the second complete thrombosis.

Partial Occlusions: as stated, operations in these patients is to a large extent a prophylactic procedure. In many patients the diagnosis can be made without the use of extensive or complicated tests. It is our opinion that greater realization of this will lead to more operations being performed at the stage of arterial stenosis and the patient thereby

concluded on next page

saved the development of a complete occlusion and perhaps a major permanent hemiplegia.

Complete Occlusions: the development of a sense of urgency amongst those who care for these patients so that operation could be performed within a few hours of the onset might well lead to considerable improvement in the results of treatment of these patients.

References

[1]Gowers, W. R.: Manual of Diseases of the Nervous System. Vol. 2. Churchill, Lond., 1888

[2]Penzoldt, F.: Ueber Thrombose der Carotis, Deutsches Arch. klin. Med. 28:80, 1880-81

[3]Hutchinson, E. C., and Yates, P. O.: Cervical Portion of Vertebral Artery; Clinico-Pathological Study, Brain 79: 319, 1956

[4]Hutchinson, E. C., and Yates, P. O.: Carotico-Vertebral Stenosis, Lancet 1:2, Jan. 5, 1957

[5]Bull, J. W. D.; Marshall, J., and Shaw, D. A.: Cerebral Angiography in the Diagnosis of Acute Stroke, Lancet 1:562, March 12, 1960

[6]Peart, W. S., and Rob, C.: Arterial Auscultation, Lancet 2:219, July 30, 1960

[7]Eastcott, H. H. G.; Pickering, G. W., and Rob, C. G.: Reconstruction of Internal Carotid Artery in a Patient with Intermittent Attacks of Hemiplegia, Lancet 2:994, Nov. 13, 1954

[8]Rob, C. G., and Wheeler, E. B.: Thrombosis of Internal Carotid Artery Treated by Arterial Surgery, Brit. M. J. 2:264, Aug. 3, 1957

JOHN F. KENNEY CLINIC DAY

WEDNESDAY, OCTOBER 31, 1962

Memorial Hospital, Pawtucket, R. I.

Sponsored by the Interns' Alumni Association

10:00 A.M. . . .

VASCULAR ACCIDENTS OF THE UPPER EXTREMITY

PAUL B. METCALF, M.D.
MAURICIO RODRIGUEZ, M.D.
PAUL J. HEALEY, M.D.

A STUDY OF POST-NATAL ALOPECIA

BENCEL L. SCHIFF, M.D.
ARTHUR B. KERN, M.D.

THE NEUROTIC PATIENT

LAURENCE A. SENSEMAN, M.D.

CARCINOID OF THE AMPULLA OF VATER

EDMUND C. BILLINGS, M.D.

HYPERTENSION AND ADRENAL TUMORS

DANIEL LIANG, M.D.

PARTIAL PITUITARY ABLATION FOR DIABETES WITH VASCULAR COMPLICATIONS

HANNIBAL HAMLIN, M.D.

METHYLENE BLUE AS A SURGICAL ADJUNCT TO GANGLIECTOMY

MICHAEL SCALA, M.D.

LUNCHEON

2:00 P.M. . . .

CURRENT CONCEPTS IN HYPERTENSION

Peter Bent Brigham Hospital

ROGER B. HICKLER, M.D., Associate in Medicine, Harvard Medical School. Senior Associate in Medicine; Director, Hypertension Unit, Peter Bent Brigham Hospital

WARREN R. GUILD, M.D., Associate in Medicine, Harvard Medical School. Senior Associate in Medicine; Associate Director, Cardiorenal Laboratory, Peter Bent Brigham Hospital

DAVID P. LAULER, M.D., Instructor in Medicine, Harvard Medical School. Junior Associate in Medicine; Associate Director, Hypertension Unit, Peter Bent Brigham Hospital

EDWARD B. HAGER, M.D., Instructor in Medicine, Harvard Medical School; Junior Associate in Medicine; Associate, Cardiorenal Group, Peter Bent Brigham Hospital

This will include discussion of what is normal blood pressure and newer concepts in humoral and renal factors, newer diagnostic procedures and recent concepts in therapy and management, to be followed by panel discussions and questions.

AIR AMBULANCE SERVICE

To any part of the country — day or night. Multi-engine equipment, air line rated pilots. Fully equipped amblance, stimulant tray, oxygen therapy etc. Registered nurse on all trips. We can transport stretcher cases in and out of the smallest airports.

No increase in rates over ground transportation

CUSHMAN'S

AIR AMBULANCE SERVICE

47 NISBET ST., PROVIDENCE, RHODE ISLAND

Call DE 1-4840

Editorials

THE NEW FRONTIER IN POLIOMYELITIS PREVENTION

IT IS URGED that everyone read Doctor Sabin's address on poliomyelitis published in this issue. It outlines what may be called the "New Frontier" in poliomyelitis prevention. We are convinced that the Sabin vaccine is the immediate answer to the problem. Doctor Sabin is an extremely persuasive speaker and obviously an authority in this field. Some observers feel that he has been rather cavalier in his rejection of the Salk vaccine. It would be interesting to hear Doctor Salk's refutation of Doctor Sabin's arguments.

Our neighboring states have been active in administering Sabin vaccine in the past months, and the question has been asked many times, "Where is Rhode Island?" It was felt that Rhode Island was unique in many ways, one being that our utilization of the Salk vaccine was so nearly complete that the population had been pretty well protected against poliomyelitis. There is little question that the Salk vaccine has lowered the incidence of polio markedly. The mechanics and technique of administering the Sabin vaccine, while rather simple, are complicated by some minimal storage requirements and dating. Much has been said about the "wild enteroviruses" which may hamper antibody formation, especially during the summer months. With these facts, and others, in mind it was decided to recommend that Rhode Island not enter into a program using Sabin vaccine until the fall of 1962 at the earliest. How the program will be undertaken is as yet undecided.

A number of medical societies have been successful in sponsoring widely applied programs in their communities sometimes charging a nominal sum to pay for supplies. These have evidently been carried out alone or in collaboration with the departments of health. There is a good deal of merit in having this sort of a program in Rhode Island. It would be accomplished, possibly, in one day, and a certain amount of "herd immunity" would develop, which authorities feel extends the protection.

If we assume such a program to be of value, it would appear desirable that it be applied on a statewide basis, withdrawing it temporarily from the hands of private practitioners and administering it through the Medical Society. This could well be done on a "crash" basis with the three doses being given a month apart, after which the local health departments could continue it for welfare patients. The office administration of the oral vaccine could then be continued for infants. The Rhode Island Medical Society, with the co-operation of the state Department of Health, should manage such a program.

The argument that a program of this nature encroaches upon the private practice of medicine has little validity since physicians themselves would be responsible. It is difficult to envision a more efficient, successful, or painless program for the benefit of the public. The occurrence of a few cases of paralytic poliomyelitis in Canada and also in the United States following the administration of Type III Sabin vaccine has caused some concern about the safety of this vaccine. The Surgeon General of the United States Public Health Service has recommended that adults not be given Type III vaccine of the live variety, but that the mass immunization program otherwise not be modified. The effect of this new information on the recommendations of the local Poliomyelitis Advisory Committee is not known at this writing. It should be emphasized, however, that, whatever the significance of the reported cases, the incidence, considering the millions of doses administered, is extremely small. The Child-School Health Committee is expected to make a recommendation along these lines to the House of Delegates.

MECHANICAL MEDICINE — "TENDER LOVING CARE" BY MACHINE?

NO ONE CAN DENY the great value of the various mechanical, electrical, and related types of apparatus now in use in the diagnosis and treatment of diseased human beings. Such instruments, developed by modern engineering skill and based on the advancement of knowledge in the fields of physics, chemistry, and other basic sciences, are of the utmost importance in medicine. Radiologic and

continued on next page

electrocardiographic examinations, to cite two of the more familiar procedures, yield diagnostic information that saves many lives every day of the year.

If we should wish to forecast the future developments of such agencies carried to the point of absurdity we could visualize a machine-hospital in which the patient would be placed on a moving surface, a sort of diagnostic assembly line, and after receiving a tranquilizing medication he would be passed along while undergoing a series of mechanical tests and measurements. Pulse, temperature, blood pressure, weight, and various measurements would be automatically recorded on punch cards and blood would be drawn for tests, X-rays taken, and the details of a physical examination determined and also represented by appropriate holes in the punch cards. Then, as a result of determinations by a computer he would be sent on to stop at various stations for further specialized tests as indicated. In less than a half hour he would be deposited in a hospital bed along with a complete record of the diagnosis and a detailed statement of the appropriate treatment. There would be nothing left to do but carry out this treatment and most of it, too, could be done by mechanical means. This would be wonderful indeed, for guinea pigs or even rats or dogs, perhaps; but for human beings it would leave half, and often more than half, of the patient's care not done.

The reason is clear. The guinea pig or even the dog, if not in pain, given normal appetite and available food, will be content. Not so the human being. Though his illness may not cause him pain at the moment, he remembers the past and he fears the future. He wonders what the illness means to him, to his family, his business, and to his chances of success in everything that he is trying to accomplish in life. Will the "awful pain" that he had recur? Will he be damaged permanently? The machines won't tell him, even if they were able to turn out a written statement indicating his prognosis and even suggest concern for his welfare. A thousand anxious thoughts pass through his mind, and naturally he can't sleep well or take the nourishment that is offered to him.

But if at this time his doctor, his old and trusted friend, should come in and sit down at the bedside the whole picture would change. How many of us have experienced the relief that this brings, especially when our treatment had been as impersonal as it often is found to be in some clinics and hospitals! If the patient has normal intelligence it may take but a few words of explanation and reassurance to bring relief and hope. The patient will often then go about the task of getting over his illness with a new spirit, even accepting with good grace the discomforts of the various procedures, the need for which he now begins to understand. This renewed spirit will be a real factor in his recovery.

Today when an understanding of the *science* of medicine demands so much of the physician, there is a real danger that the *art* of medicine, the ability to deal with a patient with a kindly skill that indicates that it is recognized that he is something more than a problem in abnormal physiology, may be neglected and even to a great extent lost. How common it is to see a physician who is an excellent medical scientist but a mighty poor doctor! How often a physician does not realize as he stands at the patient's bedside that very frequently what the patient hears him say may be more important than what he, the doctor, writes in the order book. Many times it is more disastrous to say the wrong thing than it is to order the wrong medication.

These two great phases of medicine, the science and the art, must go together. The science furnishes the means, the tools we might say, and the art supplies the method of successful application of these to the sick human being. Working with the myriad medications and methods that science provides for us to use in our efforts to save lives and prevent suffering we must never forget that we are not treating disease but *people*. One of the most important educational experiences that can come into the life of a physician is for himself to suffer a serious illness. He will then have a better understanding of what it is that the sick and frightened patient really needs and he will be able more effectively to help those who put themselves in his hands, giving them hope and comfort that cannot be synthesized in the laboratory, measured by computers or applied by a machine.

THE DOCTORS' RIGHT TO LOBBY

WHAT RIGHT has the doctor to lobby relative to legislation before federal, state or municipal bodies? With elections ahead, and mindful of the experience of our own Society members when they sought to present their views on local legislation earlier this year, the question is of paramount importance, both to the profession and to the public.

The doctor, as any citizen, certainly has a right to express his views on any and all legislation. But when he speaks on legislative proposals affecting health and welfare he finds himself unduly criticized. Yet, like any person engaged in a specific art or craft, he has an intimate knowledge by reason of his life career that qualifies him eminently as a critic of such proposals which may not be in the

best interests of good health for the public.

Within the year we have noted that many groups in our communities have been outspoken on legislative proposals — national, state and local — and their views, however forcibly expressed, were accepted without acrimonious replies. Yet when the medical profession, as a group, or through its official spokesmen, expressed its opinions, the criticisms were promptly raised that "the doctors had a selfish view in mind," or they were "mimicking the American Medical Association," or the spokesmen did not "speak for all the doctors." By what strange quirk is the doctor and his medical society treated differently than others when legislative proposals are criticized?

One of the most interesting reviews of the doctors' right to lobby has been set forth by Rt. Rev. Msgr. Timothy P. O'Connell, of Worcester, who wrote in the CATHOLIC FREE PRESS last April that

"Problems need tedious and patient attention often to technical details and proper balance of various interests if injustice is to be avoided. So it is important that the physician be heard and what he has to say weighed well.

"A criticism voiced by the advocates of social reforms, be it of the aged or some other group, is that the physician is just a reactionary when he views with some alarm a social program which, in its advocated form, he feels can work more harm than good.

"When the physician speaks out individually or through his professional organizations against the encroaching dangers of social medicine which he sees in a given program, it is not to be interpreted as indifference to the problem. The values he is likely to stress have vital importance and should not be overlooked in the mass of statistics offered to win public approval and support for a given social program."

Pursuing his review of the problem, Monsignor O'Connell brings into sharp focus the personal and private relationship set up between a patient and his physician which can never be absorbed in the automation of the day in which complete impersonality has become dominant, and he notes that

"Many take this relationship for granted and believe that, no matter what happens, it will always remain. However, unfortunately, they overlook the fact that a solution to a social program can be adopted which may bring with it the great danger of destroying the personal and intimate professional relationships. The physician knows this danger so he warns that no program should ever be adopted that will hamper or destroy this vital, meaningful and necessary relationship.

"The physician, therefore, when he speaks out on a particular problem does so to defend a very vital area which he foresees can be threatened or destroyed. This he should do because he is fighting for the personal rights of his patient and his own professional integrity. He should do so because he is the best-qualified person to know the harm that could come to all of us if any program were adopted which would destroy this relationship.

"His defense, therefore, should never be interpreted as a callous indifference to the misery of some group. Their miseries, in fact, would become even worse if the doctor lost his private and personal relationship toward their pains and aches."

Pointing out that medicine in the United States has been developed by preserving its independence from political control, Monsignor O'Connell maintains that precisely because the best medicine in the world is practiced in this country foreign students wish avidly to study here. Just how avidly they desire to gain medical training is apparent when one realizes that 8,497 foreign physicians from 94 countries came to the United States this year, of whom 7,286 were training as residents and 1,211 as interns. Any change in our system of medicine that would jeopardize the further development of medicine, or cause stagnation, or produce slow rot in this field, should not be made, says Monsignor O'Connell.

Further clarifying the position of the physician in speaking out, as a citizen-physician, or as a lobbyist, he states

"Now, when a physician speaks out against some proposed social program, a valid and necessary distinction should always be made. He is not, by his opposition, necessarily denying the existence of any given problem. But he must weigh the methods proposed for its solution. If some mechanism were adopted which is supposed to solve an existing problem and the physician sees in it a threat to one of the basic foundations of medicine such as its independence, which medicine needs for its vitality and growth, then he must speak out.

"There seems to be little doubt that outside interference and control be it from bureaucrats or well-meaning people will hamper the development of medicine and the physician, since independence seems to be necessary for the vitality and growth of both. One could easily visualize the harm that could be done if there were any control placed over medicine such as now and then is exercised by some senior officer in the armed services over his subordinates who are superior to him in knowledge, technique and training. In such a rigid setup, initiative is not welcomed but discouraged because the line of command must be primarily preserved. Such a

concluded on next page

system may have justifying reasons in the armed services but the imposition of such a system on all of medicine would cause it to decay.

"Perhaps in no other field is private evaluation of a situation, initiative and departure from traditional norms and methods so needed as in the practice of medicine. Anything which would debilitate or destroy these qualities of character in a physician would serve neither the cause of science nor medical practice nor patient care.

"It is, therefore, right for the doctor to speak out and to protect himself and all of us for that matter from any program for the medically indigent which he feels would directly or indirectly take away the independence of the doctor and his freedom to perfect medical science and his personal relationship with the patient as long as his peers consider him qualified."

Noting that it is in the public interest for all to realize that social problems are not simple to solve, and that in any problem there are many aspects which have to be considered and equitably evaluated if a correct solution is to be found, the noted Worcester theologian points out in his article that "debate should go on and we should listen carefully to what both sides say and refuse to be blinded by panaceas offered by well-meaning people unconscious often of the implications in their favorite programs."

The actions in recent years of our state legislators in approving proposals that would literally over night make nonmedical groups "purveyors of medical service" by legislative enactment rather than educational qualification have been most disturbing to Rhode Island physicians. We are impressed with Monsignor O'Connell's concluding remarks on legislatures, and we commend them to our readers:

"So, before there are any brickbats thrown at the accredited spokesmen of medicine when they speak out, one should look first around and see what the legislatures now permit to flourish in some communities, particularly when the legislatures in some states will not adopt the proper standards set up for the sound practice of medicine by authorized spokesmen and bodies or listen to their spokesmen when they ask that their social legislation not threaten the very essentials of good medical care and the vitality of the science of medicine.

"The public in general, of course, has to depend on their legislatures to look out for their interests in these areas and to be objective and informed about whatever program or statutes which are to be adopted. Certainly, vested interests or programs popular but unsound are not sufficient reason to permit abuses to continue to exist or to come into being which would or do subject the citizen to the danger of being exposed in such a manner that his life and limbs are put in jeopardy or his care become a perfunctory and impersonal performance."

LIFE INSURANCE or DEATH INSURANCE?

SOME Medical men need DEATH Insurance ONLY.

Others need accumulating, guaranteed dollar values to meet their LIVING needs in the future — DEPRESSION — EMERGENCY — RETIREMENT, etc.

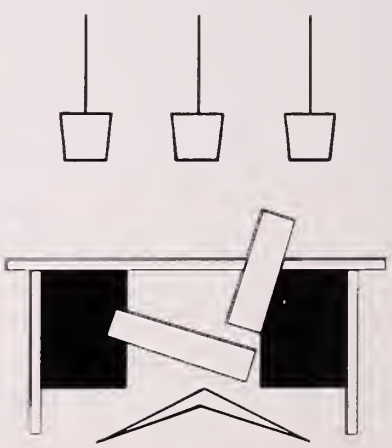
In any event, our new "CHEAPER-THAN-TERM" DEATH INSURANCE is the first step in the right direction!

Don't make any important changes in your Life Insurance or Estate plans without investigating "CHEAPER-THAN-TERM"!

For further information about this sensational new development in DEATH INSURANCE, write or phone:

ROLAND A. DEROSIER
54 Custom House Street
Providence 3, Rhode Island
TE 1-4833

Attractive & Functional Offices
by BENÉ & CO., INC.



Designers & Suppliers of Offices
150 Dorrance Street • Providence 3, R. I. • GAspee 1-5228

INDICATION: *Accidental trauma*



INDICATED:
Chymoral®

cuts healing time in accidental trauma

Whether the patient presents the simple edema and inflammation of a sprained ankle or the severe lacerations and bruising from a violent accident, immediate adjunctive use of Chymoral speeds resolution of traumatic manifestations. Chymoral modifies the inflammatory reaction to trauma, dissipates edema and blood extravasates, improves regional circulation, and thus aids the body's natural reparative activities. In other general practice areas, too, Chymoral cuts healing time. Excellent results have been achieved in acute sinusitis, bronchitis, bronchial asthma, emphysema, chronic pelvic inflammatory disease, and acute thrombophlebitis.[1-5]

Controls inflammation, curtails swelling, curbs pain

1. Beck, C., *et al.*: Clin. Med. 7:519, 1960. 2. Teitel, L. H., *et al.*: Indust. Med. 29:150, 1960. 3. Billow, B. W., *et al.*: Southwestern Med. 41:286, 1960. 4. Clinical Reports to the Medical Department, Armour Pharmaceutical Company, 1960. 5. Taub, S. J.: Clin. Med. 7: 2575, 1960.

ARMOUR PHARMACEUTICAL COMPANY
KANKAKEE, ILLINOIS
Originators of Listica®

CHYMORAL

Chymoral is an ORAL anti-inflammatory enzyme tablet specifically formulated for intestinal absorption. Each tablet provides enzymatic activity, equivalent to 50,000 Armour Units, supplied by a purified concentrate which has specific trypsin and chymotrypsin activity in a ratio of approximately six to one. ACTION: Reduces inflammation of all types; reduces and prevents edema except that of cardiac or renal origin; hastens absorption of blood and lymph extravasates; helps to liquefy thick tenacious mucous secretions; improves regional circulation; promotes healing; reduces pain. INDICATIONS: Chymoral is indicated in respiratory conditions such as asthma, bronchitis, rhinitis, sinusitis; in accidental trauma to speed absorption of hematoma, bruises, and contusions; in inflammatory dermatoses to ameliorate acute inflammation in conjunction with standard therapies; in gynecologic conditions such as pelvic inflammatory disease and mastitis; in obstetrics as episiotomies and breast engorgement; in surgical procedures as biopsies, hernia repairs, hemorrhoidectomies, mammectomies, phlebitis and thrombophlebitis; in genitourinary disorders as epididymitis, orchitis and prostatitis; in dental and oral surgery as fractures of the mandible or maxilla, difficult or multiple extractions, and alveolectomies. CONTRAINDICATIONS: None known. INCOMPATIBILITIES: None known. Antibiotics as well as generally accepted measures may be coadministered. SIDE EFFECTS: Mild gastric upsets, rarely encountered. DOSAGE: Recommended initial dose is two tablets q.i.d.; one tablet q.i.d. for maintenance. SUPPLIED: Bottles of 48 and 250 tablets.

CHYMORAL *ORAL systemic anti-inflammatory enzyme tablet*

REPORT ON THE ACTIONS OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION

111th Annual Meeting, Chicago, Illinois, June 24-28, 1962

CHARLES J. ASHWORTH, M.D., DELEGATE, AND ARTHUR E. HARDY, M.D., ALTERNATE DELEGATE, OF THE RHODE ISLAND MEDICAL SOCIETY

DOCTOR EDWARD R. ANNIS, a practicing surgeon in Miami, Florida, and chairman of the A.M.A. National Speakers Bureau, was named president-elect to succeed Doctor George M. Fister of Ogden, Utah, whose term will expire in June, 1963. Doctor Annis has become nationally known as medicine's spokesman in the campaign against King-Anderson type of legislation. He addressed the annual dinner of the Rhode Island Medical Society this past May.

The House accepted a report from the Council on Medical Service with reference to the utilization of state and federal tax funds to provide voluntary prepayment health insurance protection to assist the aged in meeting the costs of health care services with approval of the following policy statement:

"1. The need for application of the prepayment or insurance principle to protect our people against the costs of medical care is fully recognized and applies to all ages rather than to the aged alone.

"2. Persons financially able to prepay their own expenses are expected to do so and must be encouraged rather than compelled to do so.

"3. Persons financially unable to prepay adequately their expenses may properly be assisted to the degree necessary by their families, their communities, their states, and if these fail, by the federal government — but only in conjunction with other levels of government.

"4. The prepayment system should be devoid of governmental controls.

"5. Dignity and self-sufficiency for the individual should be upheld.

"6. The protection offered must be reasonably comprehensive rather than token in character."

Continued firm opposition to the King-Anderson type of legislation and full support of the Kerr-Mills program was expressed in resolutions from seventeen different states. The reasons for active opposition to the King-Anderson bill in all of these resolutions were reduced to these essential four:

"1) the lack of need for such a plan.

"2) that it would provide inadequate care for all aged rather than complete care for those who need help.

"3) the fact that inherent in the use of the Social Security mechanism are governmental controls of medical practice which would increase with the expansion of the program.

"4) deterioration of the quality of medical care not only for the aged but for the population as a whole."

A fair and reasonable chance for the Kerr-Mills Act to meet the present need was urged, thereby removing the demand for further federal legislation. It also urged all state associations to "work actively with other responsible citizens in reviewing the functions of the law, evaluating its effectiveness and aggressively supporting improvements in programs to aid those aged who need help so as to achieve the provision of quality medical care and service."

Non-participation in the implementation of the King-Anderson bill was the content of one resolution introduced and upon which the House took no action. It urged, however, individual physicians to review the following sections on Principles of Medical Ethics:

"Section 1. — The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

"Section 5. — A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

"Section 6. — A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care."

The Association's fight against King-Anderson legislation was characterized by retiring president Doctor Leonard W. Larson as "this great struggle that has been testing again whether the science and

continued on page 474



Clear the air

with ALEVAIRE®

inhalation therapy

WETS, THINS, LOOSENS PULMONARY SECRETIONS

Very useful in...

... BRONCHITIS
BRONCHIAL ASTHMA
BRONCHIECTASIS
PERTUSSIS
CROUP



Alevaire is administered by means of a nebulizer operated with an air compressor or oxygen.

Supplied in bottles of 60 cc. for intermittent and 500 cc. for continuous nebulization.

Winthrop LABORATORIES
NEW YORK 18, N. Y.

Alevaire, trademark reg. U.S. Pat. Off.

HOUSE OF DELEGATES

continued from page 472

art of medicine will be permitted to grow and flourish in freedom, or whether progress in medicine will be stunted and shriveled by the excesses of governmental control."

"Refusal of the A.M.A. to compromise on basic principles has been a source of strength for us and our friends," Doctor Larson said, expressing full confidence in ultimate victory, but warning that victory will impose a solemn obligation of responsible leadership for all physicians.

The increasing tasks imposed upon visiting as well as resident staffs of hospitals throughout the country resulted in the introduction of this Resolution, #24, by the Illinois delegation, emphasizing the widespread displeasure the medical profession is experiencing as a result thereof.

Whereas, One of the recommendations made by representatives of the Joint Commission on Accreditation of Hospitals is that each chart on patients hospitalized over 48 hours, should include a summary on the progress note sheet on the date of discharge, said summary to include a short synopsis of history and symptoms, physical examination, treatment and progress of patient all of which are already on the chart; and

Whereas, Such a summary means a needless duplication of facts as well as considerable time spent by physicians recording details which are of no benefit to the patient, have nothing whatsoever to do with maintaining or improving an already high standard of patient care; and

Whereas, The summary can serve no worthwhile purpose, and will only create additional paper work for the physician, the record librarian and her assistants; therefore be it

Resolved, That the House of Delegates of the American Medical Association go on record as opposed to the requirement that a written summary be included on the patient's hospital record, and that a statement that the patient improved, recovered, died or was transferred to another hospital for treatment, is adequate and that other such meaningless and unrelated additions to requirements be deleted from record keeping requirements established by the Joint Commission on Accreditation.

The Reference Committee on Medical Education and Hospitals recommended that it be referred to the Ad Hoc Committee on House procedures, which will report back at the Los Angeles meeting.

Medical Discipline

To implement one of the major recommendations made by the Medical Disciplinary Committee at the June, 1961, meeting in New York, the House approved a change in the Bylaws under which a proposed Section 1 (B) of Chapter IV will now read:

"In addition to such disciplinary action as may be taken under the constitution and bylaws of the component society and constituent association to which the member belongs, or when a state medical association to which a member belongs requests the A.M.A. to take disciplinary action, or when at the request of the American Medical Association the state association to which the member belongs consents to disciplinary proceedings by A.M.A., the Judicial Council, after due notice and hearing, may censure him, or may suspend or expel any member of the American Medical Association from A.M.A. membership only for an infraction of the Constitution or these Bylaws or for a violation of the Principles of Medical Ethics."

A.M.A. Board of Trustees

The House approved a report of the Ad Hoc Committee on the Board of Trustees which recommended that the size of the Board be increased from 11 members to 15 members. This will be accomplished by adding three elected members and by including the immediate past president of the Association for a one-year term. The House also accepted a committee recommendation that set the term of office for elected Board members at three years and limited the number of terms to three, for a maximum total of nine years service. To implement the House action, the Council on Constitution and Bylaws submitted changes in the Constitution and Bylaws for consideration at the 1962 Clinical Meeting.

American Board of Abdominal Surgery

A study report from the Council on Medical Education and Hospitals, recommending that recognition should not be granted to the American Board of Abdominal Surgery as a specialty board, was approved by the House. In accepting the Council report, the House also declared its disapproval in principle of establishing specialties which are based largely or wholly on an arbitrarily defined anatomical region.

The study, which was carried out under instructions from the House of Delegates at the 1961 Clinical Meeting, concluded that the present contribution of the American Board of Abdominal Surgery to the advancement of surgery and the betterment of public health is inadequate in many important respects. It also concluded that the American Board of Abdominal Surgery does not offer significant potential for the advancement of surgery and the betterment of public health.

American College of Surgeons

In considering a Board report and four resolutions involving surgical assistants and relations between the A.M.A. and the American College of Surgeons, the House declared that the adoption

concluded on page 476



WITH YOUR ENCOURAGEMENT

AND

DEXEDRINE®

brand of dextro amphetamine

SPANSULE®

brand of sustained release capsules

she's losing weight

'Dexedrine' *Spansule* capsules not only control appetite all day long, but at the same time encourage normal activity. This is particularly important because overweight patients are often inactive. In such patients 'Dexedrine' overcomes lethargy, helps renew their interest in doing things—not just eating.

PRESCRIBING INFORMATION

INDICATIONS AND DOSAGE: For the following indications, the recommended daily dosage is one or two 'Dexedrine' *Spansule* capsules, usually taken in the morning: control of appetite in weight reduction; depressive states; alcoholism. In narcolepsy, the recommended daily dosage is up to 50 mg. of 'Dexedrine' by 'Spansule' capsule on arising.

SIDE EFFECTS: Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

CAUTIONS: Should be used with caution in patients hypersensitive to sympathomimetic compounds; in cases of coronary or cardiovascular disease; and in the presence of severe hypertension.

CONTRAINDICATIONS: Hyperexcitability; agitated pre-psychotic states.

SUPPLIED: 5 mg., 10 mg. and 15 mg., in bottles of 30. (Each capsule contains dextro amphetamine sulfate, 5 mg., 10 mg., or 15 mg.)

Prescribing information adopted January 1961.

Smith Kline & French SK&F *Laboratories*

HOUSE OF DELEGATES

concluded from page 474

and interpretation of the Principles of Medical Ethics is the prerogative and duty of the American Medical Association. It also restated the Association's June, 1961, policy statement in the following manner:

"(1) Each member of the A.M.A. is expected to observe the Principles of Medical Ethics in every aspect of his professional practice.

"(2) Each doctor engaged in the care of the patient is entitled to compensation commensurate with the value of the services he has personally rendered.

"(3) No doctor should bill or be paid for a service which he does not perform; mere referral does not constitute a professional service for which a professional charge should be made or for which a fee may be ethically paid or received.

"(4) When services are rendered by more than one physician, each physician should submit his own bill to the patient and be compensated separately whenever possible.

"(5) It is ethically permissible in certain circumstances, however, for a surgeon to engage other physicians to assist him in the performance of a surgical procedure and to pay a reasonable amount for such assistance. This principle applies whether or not an assisting physician is the referring doctor."

Miscellaneous Actions

In considering reports and resolutions on a wide variety of subjects, the House also:

Learned that the Board of Trustees has instructed the Council on Drugs to conduct a study on the relationship between *tobacco and disease.*

Disapproved a suggestion that the Council on Medical Education and Hospitals be replaced by *two separate councils* on undergraduate and graduate medical education.

Referred to the Board of Trustees a proposal that at least six members of the *Council on Medical Education and Hospitals* shall be engaged primarily in the private practice of medicine in hospitals without a medical school affiliation and that no more than four members may be salaried personnel of a medical school or university.

Approved a resolution that *honorariums* be provided for the Association's elected officers in amounts to be determined by the Board of Trustees.

Approved a recommendation that *A.M.A. meetings* be scheduled as follows: Annual Meetings — 1966, Chicago; 1967, Atlantic City, and 1968, San Francisco, and Clinical Meetings — 1965, Philadelphia, and 1966, Las Vegas.

Recommended that the Council on Medical Education and Hospitals conduct a study of *specialty residencies.*

Reaffirmed its opposition to *compulsory coverage of physicians* under the Social Security Act, after receiving 11 resolutions opposing coverage and only two favoring the inclusion of physicians.



We Offer the Finest Facilities for

CONVENTIONS, SEMINARS, CONFERENCE MEETINGS

1 to 400 persons

NEW MOTOR INN and ALL FUNCTION ROOMS
FULLY AIR-CONDITIONED

Outdoor Swimming Pool, Boating, Fishing, Golfing,
Historic Mansions, World Famous Ocean Drive

Viking Hotel and Motor Inn

"in the center of everything"

NEWPORT, RHODE ISLAND

Telephone 847-3300

MON., OCT. 1 . . . Scientific Meeting. Providence Medical Association. At the Medical Library, 8:30 P.M.

TUES., OCT. 2–WED., OCT. 3 . . . Congress on Occupational Health (A.M.A.). At Boston.

Symposium on RECENT CLINICAL ADVANCES IN PEDIATRICS

ROGER WILLIAMS GENERAL HOSPITAL

MAURICE N. KAY, M.D., *Chief of Pediatrics*

CHARLES A. JANEWAY, *Moderator*

October 10, 1962 Morning Session, 11:00 A.M. to 1:00 P.M.

1. ADDRESS OF WELCOME WILLIAM E. SLEIGHT

2. ADDRESS OF WELCOME MAURICE N. KAY, M.D.

SAUL KRUGMAN, M.D. . . . *"Polio Vaccines"*

Professor and Chairman, Dept. of Pediatrics, New York University School of Medicine

Director, Pediatric Service, Bellevue Hospital

Director, Pediatric Service, University Hospital

KURT HIRSCHHORN, M.D. . . . *"Chromosomes in Clinical Pediatric Diseases"*

Assistant Professor of Medicine, New York University School of Medicine; Established Investigator of American Heart Association

Assisting Visiting Physician at Bellevue Hospital

Assistant Attending Physician at University Hospital

CHARLES A. JANEWAY, M.D. . . . *"Recent Advances in Connective Tissue Disease"*

Thomas Morgan Rotch Professor of Pediatrics, Harvard Medical School

Physician-in-Chief, Children's Hospital Medical Center

Lunch, Hospital Cafeteria, 1:00 to 2:00 P.M.

Afternoon Session, 2:00 to 4:00 P.M.

EDWARD H. KASS, M.D. . . . *"Prevention of Prematurity"*

Associate Professor of Bacteriology and Immunology, Harvard Medical School

Associate Director of the Mallory Institute of Pathology, Boston City Hospital

Associate Physician, Thorndike Memorial Laboratory, Boston City Hospital

PRISCILLA WHITE, M.D. . . . *"Recent Advances in Diabetes"*

Physician, Joslin Clinic, New England Deaconess Hospital, Faulkner Hospital, Boston Lying In Hospital

Assistant Professor of Pediatrics, Tufts University Medical School

LOUIS K. DIAMOND, M.D. . . . *"Recent Clinical Advances in Hematology"*

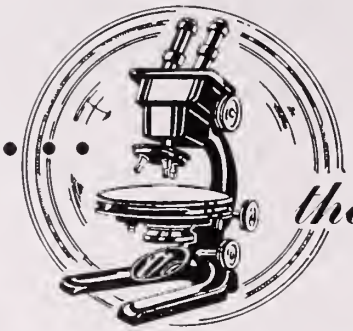
Associate Professor of Pediatrics, Harvard Medical School

Associate Chief, Medical Service, Children's Hospital Medical Center

Director of Hematology Research Laboratories, Blood Grouping Laboratory and Blood Bank, all at Children's Hospital Medical Center

Guided tour of pediatric service and hospital will be available for those who desire.

This program has been supported by Ross Laboratories and Desitin Chemical Co.

THROUGH . . .  *the Microscope*

Accidents Top Disease As Cause of Physical Impairment

"Accidents cause more physical impairments among Americans than any disease," Assistant Surgeon General A. L. Chapman, of the Public Health Service, said today. Doctor Chapman is chief of the Division of Accident Prevention.

Analyzing the latest figures from a U.S. National Health Survey study of impairments, Doctor Chapman noted that accidental injuries caused about 75 per cent of all amputations. "Among males, accidents caused five times as many amputations as all other causes combined, as well as over half of all impairments of limbs and torsos — about 7½ million cases," he said.

Among other impairments included in the analysis were:

Visual impairments: Total, about 3½ million; due to accidents, over 500,000. Among persons under 65: Total, almost 1,800,000; due to accidents, over 400,000. "Accidents cause about three times as many visual impairments among males as among females," Doctor Chapman noted.

Hearing impairments: Total, about 6 million; due to accidental injury, about 400,000. "In the 25-to-44 age bracket, the percentage of hearing impairments due to accidents is almost twice as high as in the total population — 13 per cent against 7.3 per cent," Doctor Chapman pointed out, "with males represented about three times as often as females."

Paralysis: Total, about 100,000; due to accidents, about 14,600; "but the rate among people under 45 is 20 per cent, against 14.6 per cent in the total population," the Assistant Surgeon General said.

Pfizer Laboratories Provides Medical School Scholarships

A new medical scholarship program which will provide each school of medicine in the United States with a one thousand dollar scholarship beginning with the 1962-63 school year has been established by Pfizer Laboratories, division of Chas. Pfizer & Co., Inc.

In announcing the program, Doctor Roberts M. Rees, medical director for Pfizer Laboratories, said the scholarships will be administered solely by the dean of each medical school, or by a committee established by him.

Selection may be made on the basis of academic record, financial need, or other criteria which will be determined by the medical school. The scholarships are designed primarily to apply toward academic and subsistence expenses of one student in each of the 87 medical schools in the United States.

* * *

Health Benefits Vary According to State R. I. Lowest

Hospital daily room-and-board benefits provided through group health insurance policies issued during 1961, and averaged by state, ranged from a high of $20 to a low of $10, the Health Insurance Institute reported recently.

There also was a wide variance in maximum surgical benefits, and in the benefits provided for miscellaneous hospital services, the Institute said in its report which was based on an analysis of data supplied by insurance companies which account for 74 per cent of the total group health insurance premiums in the United States. The insurance data sample consisted of 991 basic group coverages issued during 1961 protecting 72,000 employees and most of their dependents.

The average daily room-and-board benefits for all the new coverages was $15, but the average was $10 for the states of North Dakota and Rhode Island, and was $20 for the state of Arizona, said the Institute. There was a similar range in provisions for miscellaneous hospital expenses such as X-rays, laboratory charges and operating room charges.

continued on page 480

consider
the convenience
to pregnant
women of
a tablet this size



ENGRAN

Squibb Vitamin-Mineral Prenatal Supplement

FORMULA SUPPLIES 45 MG. OF IRON – AT NO EXTRA COST

The size of a prenatal vitamin-supplement tablet is important—the nausea and gastric distress often associated with pregnancy may make swallowing *anything* a real problem. Hence the small size of the Engran tablet is a great convenience to your pregnant patient, for Engran is actually the *smallest* tablet now available for prenatal vitamin-mineral supplementation. Yet only *one Engran tablet* a day will provide all these vitamins and minerals to help assure a nutritionally perfect pregnancy –

Vitamin A 5,000 U.S.P. units; vitamin D 500 U.S.P. units; thiamine 3 mg.; riboflavin 3 mg.; pyridoxine 2 mg.; vitamin B_{12} 2 mcg.; niacinamide 20 mg.; calcium pantothenate 5 mg.; vitamin C 75 mg.; calcium 100 mg.; iron 45 mg.; iodine 0.15 mg.; copper 1 mg.; magnesium 6 mg.; zinc 1.5 mg.; manganese 1 mg.

For full information see your Squibb Product Reference or Product Brief.

SQUIBB *Squibb Quality—the Priceless Ingredient*

SQUIBB DIVISION Olin

Engran® is a Squibb trademark

THROUGH THE MICROSCOPE

continued from page 478

Hospital Costs Up 1 Billion Dollars in 1961

It cost American hospitals nearly one billion dollars more to operate in 1961 than in 1960, the American Hospital Association reported recently.

The cost was $9,387,242,000 in 1961, compared with $8,420,986,000 in 1960. Nearly two thirds of the costs in both years went for payroll; $6.2 billion in 1961; $5.6 billion in 1960.

Hospitals also cared for a record number of patients — 25,474,370 — an increase of nearly half a million over 1960, according to statistics which appeared today in the annual guide issue of Hospitals, Journal of the American Hospital Association.

The information was compiled from questionnaires sent to the 6,923 hospitals listed by the A.H.A.

Average cost to the hospital per patient day rose in all categories of hospitals in 1961. In the nonfederal short-term general hospitals (which admit 91.7 per cent of all patients), the cost was $34.98, an increase of $2.75 over the $32.23 of 1960. This average included voluntary hospitals, $36.04; proprietary, $33.29 and state and local governmental, $32.27. In the long-term nonfederal hospitals the average cost in the psychiatric institutions was $5.53; tuberculosis, $14.72; long-term general, $14.49. The federal hospital average was $23.34.

Commenting on the increasing costs, Edwin L. Crosby, M.D., director of the Association, said, "Most of the increase results from rising labor costs, as salaries rise generally and as more highly skilled employees are needed to provide today's highly specialized care."

Quarterly Publication Available Free to Physicians

Publication of a new quarterly, Clinical Notes on Respiratory Diseases, has been launched with a summer issue by National Tuberculosis Association and its medical section, American Thoracic Society, which also publishes the monthly journal American Review of Respiratory Diseases.

Clinical Notes is designed primarily for the general practitioner, and is a 16-page handy guide to treatment and diagnosis of respiratory diseases, including tuberculosis. The Rhode Island Tuberculosis and Health Association, through its annual Christmas Seal Campaign, offers subscriptions without cost to any physician in the state who wishes to receive it.

Introducing the first issue, the editors point out that the physician in private practice sees more disease of the respiratory system than of any other part of the human body, and that this is a field of medicine rapidly changing with the introduction of new methods of diagnosis, treatment, and prevention. Physicians may therefore find it difficult to keep up with everything that is new and applicable in their care of patients with respiratory disease.

The magazine will appear in June, September, December and March. Each issue will carry an original practical article on a subject such as the differential diagnosis or treatment of a respiratory disease, or a review of recent developments in a respiratory disease field. There will also be a featured full-page medical illustration of an important respiratory disease topic; a review of significant contributions from the medical literature, and short features including a question-and-answer column, case study with diagnosis withheld until the reader makes his own, and announcements of books, films, courses, etc.

Physicians wishing to inspect the first issue or to be put on the mailing list should contact the Rhode Island Tuberculosis and Health Association, 76 Dorrance St., Providence, or call at GAspee 1-9118.

The Association also has free copies available of the 1961 revision of Diagnostic Standards and Classification of Tuberculosis, Chemotherapy of TB, and Newest Practices in TB Treatment.



Fuller

Memorial Sanitarium

Located on Rt. 1

South Attleboro, Massachusetts

A modern non-profit hospital for the care and treatment of nervous and emotional disorders as well as long term geriatric problems.

Physical, neurological, psychiatric and psychological examinations.

Modern recognized psychiatric therapies.

A pleasant homelike atmosphere in a beautiful and conveniently located institution.

L. A. Senseman, M.D., F.A.P.A., Medical Director
Edwin Dunlop, M.D. Michael G. Touloumtzis, M.A.
Oliver S. Lindberg, M.D. William H. Dunn, M.S.W.
W. H. Lesovsky, M.D., Ph.D.

Referred patients are seen daily (except Saturdays) 9-12 A.M., and by appointment.
R. I. Blue Cross Benefits Tel. Southgate 1-8500

Special Rates for Long-Term Care

Accident Toll Rises; 47 Million Injured

The upward trend in accidents continued during 1961 when an average of 130,000 persons suffered accidents each day of the year, the Health Insurance Institute reported recently.

A total of 47.1 million persons suffered injuries last year causing one or more days of restricted activity or requiring medical attention, said the Institute in reporting on data developed by the U.S. Public Health Service.

The 1961 total matches the figures for 1958. There was a sizable drop in accidents during 1959 when 43 million persons were injured. But the trend was upward in 1960, with 46.4 million persons injured, and continued last year.

The summer months of July, August and September — as usual — accounted for the biggest quarter in accidents last year, said the Institute. The third quarter of 1961 produced 13.6 million injuries. The final three months of the year had 12.1 million.

Again last year, home sweet home was responsible for the largest portion of the accidents. Some 20.6 million persons were injured in home accidents last year, compared to 19.0 million in 1960.

However, injuries due to motor vehicle accidents declined, with 4.4 million persons injured last year, a significant decrease from the 5.0 million of 1960.

Injuries while at work also decreased, falling to 7.6 million persons so injured from the 1960 figure of 8.7 million.

A.M.A. Lists National Congress on Mental Illness

The American Medical Association will hold its first National Congress on Mental Illness and Health in Chicago, October 4-6.

The purpose of this Congress, held with the cooperation of the American Psychiatric Association and the support of the National Association for Mental Health, is to implement the broad, new mental health program developed by the A.M.A.'s Council on Mental Health. This program represents years of study and discussion and draws heavily upon sources such as *Action for Mental Health,* the A.M.A.'s Preliminary Conference on Mental Illness and Health, and meetings with the chairmen of the A.M.A.'s State Committees on Mental Health.

The three days of the Congress will be devoted to planning specific activities implementing the A.M.A. program. There will be no formal presentation of papers or discussions leading to new position papers on mental health problems — the guidelines for the Congress are spelled out in the program. Participants will meet in both topical and regional discussion groups to develop co-ordinated and continuing mental health programs to be carried out at the national, state and local levels.

Medical Communication Study

Physicians make use of a variety of communication channels to keep abreast of medical advances. In an analysis of medical communication, *Patterns of Disease,* a monthly Parke, Davis & Company publication for the medical profession, reports that it would take a physician three years and 161 days to read all the physiologic literature published in 1960, assuming he read at a rate of one page every two minutes during an eight-hour day.

A survey of physicians by *Patterns* asked which medium of communication they find most effective. Of the more than 5,000 who responded 40% indicated a preference for publications such as journals and books, 23% preferred courses in postgraduate or continuing medical education, 19% chose discussion with colleagues, 14% cited medical meetings, while 4% preferred programs for physicians on FM radio and closed-circuit television.

According to a count made by the National Library of Medicine, there were almost 6,000 medical journals published throughout the world in 1960, compared with 850 in 1879. In addition, *Patterns* reports, more than 3,000 books in medical and allied sciences are published each year.

National Air Pollution Conference Planned

A National Conference on Air Pollution, sponsored by the Public Health Service, will be held at

concluded on next page

One Caution When You Buy Mink...



Consult a reliable furrier who is interested in protecting your interests, with honest value and guaranteed quality. Come to Harris, and buy with confidence!

WILLIAM H. Harris

New England's Largest Exclusive Furrier
400 Westminster Street
Our 2nd Half-Century of Fine Fur Tradition

the Sheraton-Park Hotel in Washington, D.C., on December 10-12, Surgeon General Luther L. Terry announced recently.

Using the theme, *Let's Clear the Air*, the conference will bring together doctors, engineers, scientists, legislators, and representatives of business, labor, and civic organizations to explore how air pollution can be better controlled throughout the country.

University of Pennsylvania Cites Rhode Islander Physicians

Distinguished Senior Alumnus Awards were made recently to Doctors Halsey DeWolf, Francis H. Beckett, and Frederick A. Smith by the University of Pennsylvania. Each of the physicians received his award and citation in private ceremonies when members of the Rhode Island Medical Society and graduates of the University of Pennsylvania relayed the greetings of the University and presented the citation.

Doctor Halsey DeWolf, a native of Providence, was graduated from the University of Pennsylvania School of Medicine in 1897. He was president of the Rhode Island Medical Society in 1924, 1925 and 1926.

Doctor Francis H. Beckett, a native of Fall River, Massachusetts, was graduated from the University of Pennsylvania School of Medicine in 1902. He has served on the staffs of all the major Providence hospitals. He is still in active practice on Waterman Street.

Doctor Frederick A. Smith was graduated from the University of Pennsylvania School of Medicine in 1911 and he has practiced in Rhode Island since that date.

No Rate Increase for Federal Employees Health Plan

The premium rates of the Government-wide Service Benefit Plan and the Government-wide Indemnity Benefit Plan, which together cover about 80 per cent of the nearly 2,000,000 employees enrolled in the Federal Employees Health Benefits program, will not be increased for the next contract year which begins November 1, 1962, the Commission announced recently. The Commission also said that the next "open season" of the program is planned for late 1963, probably in October.

A few of the other 35 plans participating in the program may require premium rate increases. While some plans may make minor perfecting changes in benefits, rate increases will be negotiated only on the basis that they are needed to maintain the proper balance between the cost of present benefits and premium rates, However, any increases in rates by other plans for the next contract year will probably be small, the Commissioner said.

Although there will be no general "open season" in October of 1962, eligible employees who have previously elected not to enroll will have another opportunity to enroll in a participating plan in October of this year. Also, any employee now enrolled for self-only will be able to change to a self-and-family enrollment in the same plan and option at that time. During a general "open season" eligible employees have an unrestricted opportunity to change from one plan or option to another or, if not enrolled, to enroll in a plan.

The decision to hold no "open season" in 1962 was made after consultation with the Federal Employees Health Benefits Advisory Committee. The Committee was established under the Federal Employees Health Benefits Act of 1959 and advises the Commission on matters of concern to employees under the health benefits program.

WED., OCT. 10... Pediatric Seminar, Roger Williams Hospital. 11 A.M.-4 P.M.

MON., OCT. 15–FRI., OCT. 19... American College of Surgeons. At Atlantic City, N. J.

SAT., OCT. 20... DINNER-DANCE, Auxiliary of R. I. Medical Society.

OCT.... Dr. Isaac Gerber Oration, Miriam Hospital, 8:30 P.M.

E. P. ANTHONY, INC.
Druggists
WILBUR E. JOHNSTON, Phar. D.
RAYMOND E. JOHNSTON, B.S.
178 ANGELL STREET
PROVIDENCE, R. I.
GAspee 1-2512
Pharmacy License #225

Curran & Burton, Inc.
INDUSTRIAL
AND WHOLESALE
COAL **OIL**
17 CUSTOM HOUSE STREET
PROVIDENCE, R. I.
DExter 1-3315

AN AMES CLINIQUICK®
CLINICAL BRIEFS FOR MODERN PRACTICE

WHY TEST URINE ROUTINELY FOR PROTEIN ?

In a recent series of 278 diabetic patients, 34.2 per cent (95) had proteinuria. Of this group, almost 3 out of 5 had previously unrecognized renal disease, usually asymptomatic and untreated.[1] Proteinuria may give valuable warning not only of infectious and other renal disorders, but also of degenerative diabetic nephropathy.[2]

With URISTIX Reagent Strips, testing for proteinuria *and* glucosuria may be conveniently done at the same time. URISTIX is "...reliable for routine clinical use."[1] It will not give false-positive protein reactions with oral hypoglycemic agent metabolites. URISTIX is simple for patients to use at home and is timesaving for technicians.[1]

References: (1) Moss, J. M.; Schreiner, G. E., and Sweeney, V.: M. Times *89*:12 (Jan.) 1961. (2) El Mahallawy, M., and Sabour, M. S.: J.A.M.A. *173*:1783 (Aug. 20) 1960.

for broader day-to-day protection of the diabetic patient

DIP AND READ

uristix®

urine protein • glucose

AMES COMPANY, INC Elkhart • Indiana Toronto • Canada

1 dip . . . 10 seconds . . . 2 readings

available: URISTIX Reagent Strips, bottles of 125

20062

BOOKS RECEIVED FOR REVIEW

The Rhode Island Medical Society Library

WE ACKNOWLEDGE THE RECEIPT of the following books and thank the publishers for sending them. Some of these volumes will be reviewed from time to time. We shall be happy to furnish our readers with additional information on all books included on this list.

TEXTBOOK OF OPHTHALMOLOGY by Francis Heed Adler, M.D. 7th ed. 560 pp. illus. $9.00. W. B. Saunders Co., West Washington Sq., Philadelphia 5, 1962.

PRACTICAL ANESTHESIOLOGY by Joseph F. Artusio, Jr., M.D., and Valentino D. B. Mazzia, M.D. 318 pp. illus. $7.75. The C. V. Mosby Co., 3207 Washington Blvd., St. Louis 3, 1962.

MEDICAL PHYSIOLOGY. Edited by Philip Bard. 1339 pp. illus. $16.50. The C. V. Mosby Co., 3207 Washington Blvd., St. Louis 3, 1962.

CURRENT DIAGNOSIS & TREATMENT by Henry Brainerd, M.D., Sheldon Margen, M.D., Milton J. Chatton, M.D. and Associate Authors. 758 pp. $8.50. Lange Medical Publications, Los Altos, Calif., 1962.

HYPERTENSION. Recent Advances. The Second Hahnemann Symposium on Hypertensive Disease. Edited by Albert N. Brest, M.D. and John H. Moyer, M.D. 660 pp. illus. $12.00. Lea & Febiger, 600 So. Washington Sq., Philadelphia 6, 1961.

PRIMER OF CLINICAL MEASUREMENT OF BLOOD PRESSURE by George E. Burch, M.D. and Nicholas P. DePasquale, M.D. 141 pp. illus. $5.50. The C. V. Mosby Co., 3207 Washington Blvd., St. Louis 3, 1962.

A STUDY OF PSYCHOPHYSICAL METHODS FOR RELIEF OF CHILDBIRTH PAIN by C. Lee Buxton, M.D. 116 pp. $4.75. W. B. Saunders Co., West Washington Sq., Philadelphia 5, 1962.

THE DOCTOR BUSINESS by Richard Carter. Dolphin Books. 276 pp. 95¢. Doubleday & Co., Inc., Garden City, N.Y. New revised ed., 1961.

CIBA FOUNDATION STUDY GROUP No. 8. Problems of Pulmonary Circulation in Honour of Prof. G. Liljestrand. Editors for the Ciba Foundation: A. V. S. de Reuck, M.SC., D.I.C., A.R.C.S. and Maeve O'Connor, B.A. 96 pp. illus. $2.50. Little, Brown & Co., 34 Beacon St., Boston 6, 1961.

CIBA FOUNDATION STUDY GROUP No. 9. Progesterone and the Defence Mechanism of Pregnancy in Honour of Dr. G. W. Corner. Editors for the Ciba Foundation: G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Margaret P. Cameron, M.A. 108 pp. illus. $2.50. Little, Brown & Co., 34 Beacon St., Boston 6, 1961.

CIBA FOUNDATION STUDY GROUP No. 10. Biological Activity of the Leucocyte in Honour of Professor A. Vannotti. Editors for the Ciba Foundation: G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Maeve O'Connor, M.A. 120 pp. illus. $2.50. Little, Brown & Co., 34 Beacon St., Boston 6, 1961.

CIBA FOUNDATION STUDY GROUP No. 11. The Mechanism of Action of Water-Soluble Vitamins. Editors for the Ciba Foundation: A. V. S. de Reuck, M.SC., D.I.C., A.R.C.S. and Maeve O'Connor, B.A. 120 pp. illus. $2.50. Little, Brown & Co., 34 Beacon St., Boston 6, 1961.

CIBA FOUNDATION SYMPOSIUM ON THE NATURE OF SLEEP. Editors for the Ciba Foundation: G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Cecilia M. O'Connor, B.SC. 416 pp. illus. $10.00. Little, Brown & Co., 34 Beacon St., Boston 6, 1961.

CIBA FOUNDATION SYMPOSIUM ON QUINONES IN ELECTRON TRANSPORT. Editors for the Ciba Foundation: G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Cecilia M. O'Connor, B.SC. 453 pp. illus. $11.00. Little, Brown & Co., 34 Beacon St., Boston 6, 1961.

CIBA FOUNDATION SYMPOSIUM ON RENAL BIOPSY. Clinical and Pathological Significance. Editors for the Ciba Foundation: G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Margaret P. Cameron, M.A. 395 pp. illus. $10.50. Little, Brown & Co., 34 Beacon St., Boston 6, 1962.

CIBA FOUNDATION SYMPOSIUM ON SOMATIC STABILITY IN THE NEWLY BORN. Editors for the Ciba Foundation: G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Maeve O'Connor, B.A. 393 pp. illus. $10.00. Little, Brown & Co., 34 Beacon St., Boston 6, 1961.

continued on page 486



a relaxed mind in a relaxed body

with

Trancopal®

Brand of chlormezanone

effective TRANQUILIZER ■ potent MUSCLE RELAXANT

When you prescribe Trancopal you can see how this "tranquilaxant" speedily helps the anxious patient. It quiets his psyche — and this quieting helps relax tense muscles. It eases muscle spasm — and this easing helps put the mind at rest.

DeNyse[1] notes that the effect of Trancopal as a quieting agent ". . . may play a part in the skeletal muscle relaxing results obtained." Gruenberg[2] used Trancopal to treat patients with musculoskeletal disorders, and commented: "In addition to relieving spasm and pain, with subsequent improvement in movement and function, Trancopal reduced restlessness and irritability in a number of patients."

Trancopal has an unsurpassed record of safety. Very few side effects occur with Trancopal. You may see them in only about two out of a hundred patients, and they will almost always be mild.

Available: 200 mg. Caplets® (green colored, scored), bottles of 100
100 mg. Caplets (peach colored, scored), bottles of 100

Dosage: Adults, 1 Caplet (200 mg.) three or four times daily;
children (5 to 12 years), from 50 to 100 mg. three or four times daily.

Before prescribing, consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

References: 1. DeNyse, D. L.: M. Times *87*:1512 (Nov.) 1959.
2. Gruenberg, F.: Current Therap. Res. *2*:1 (Jan.) 1960.

Winthrop LABORATORIES New York 18, N.Y.

1649M



BOOKS RECEIVED FOR REVIEW

continued from page 484

HOW TO LIVE WITH ARTHRITIS by Ernest H. Coolidge. A Reflection Book. 122 pp. $3.00. Carlton Press, Inc., 84 Fifth Ave., New York 11, 1962.

THE COMPLEAT PEDIATRICIAN. Practical, Diagnostic, Therapeutic and Preventive Pediatrics for the Use of General Practitioners, Pediatricians, Interns and Students by Wilburt C. Davison, M.D. and Jeana Davison Levinthal, B.A., M.D. 8th ed. rev. $4.50. Printed by Seeman Printery for Duke University Press, Durham, N.C., 1961.

THE SCIENCE OF DREAMS by Edwin Diamond. 264 pp. $4.50. Doubleday & Co., Inc., Garden City, N.Y., 1962.

STRONG MEDICINE by Blake F. Donaldson, M.D. 245 pp. $3.95. Doubleday & Co., Inc., Garden City, N.Y., 1962.

TRAITOR WITHIN. Our Suicide Problem by Edward Robb Ellis and George N. Allen. 237 pp. $3.95. Doubleday & Co., Inc., Garden City, N.Y., 1961.

PSYCHOLOGICAL DEVELOPMENT IN HEALTH AND DISEASE by George L. Engel, M.D. 435 pp. $7.50. W. B. Saunders Co., West Washington Sq., Philadelphia 5, 1962.

MEDICAL STATE BOARD QUESTIONS AND ANSWERS by Harrison F. Flippin, M.D. 10th ed. 507 pp. $9.50. W. B. Saunders Co., West Washington Sq., Philadelphia 5, 1962.

GENERAL PATHOLOGY. Based on Lectures Delivered at the Sir William Dunn School of Pathology, University of Oxford. Edited by Sir Howard Florey. 3rd ed. 1104 pp. illus. $22.00. W. B. Saunders Co., West Washington Sq., Philadelphia 5, 1962.

THE ABORTIONIST by Dr. X as Told to Lucy Freeman. 216 pp. $3.95. Doubleday & Co., Inc., Garden City, N.Y., 1962.

CARCINOMA OF THE CERVIX by John B. Graham, M.D.; Luciano S. J. Sotto, M.D. and Frank P. Paloucek, M.D. 487 pp. illus. $14.00. W. B. Saunders Co., West Washington Sq., Philadelphia 5, 1962.

PEDIATRIC DIAGNOSIS. Interpretation of Signs and Symptoms in Different Age Periods by Morris Green, M.D. and Julius B. Richmond, M.D. 2nd ed. 541 pp. illus. $13.00. W. B. Saunders Co., West Washington Sq., Philadelphia 5, 1962.

PSYCHIATRY. Biological and Social by Ian Gregory, M.A., M.D. (Camb.), D.PSYCH. (Tor.), M.P.H. (Mich.). 577 pp. $10.00. W. B. Saunders Co., West Washington Sq., Philadelphia 5,

1961.

POSTPARTUM PSYCHIATRIC PROBLEMS by James Alexander Hamilton, PH.D., M.D. 156 pp. $6.85. The C. V. Mosby Co., 3207 Washington Blvd., St. Louis 3, 1962.

IRRITATION AND COUNTERIRRITATION. A Hypothesis about the Autoamputative Property of the Nervous System. A Scientific Excursion into Theoretical Medicine by Adolphe D. Jonas, M.D. 368 pp. $7.50. Vantage Press, Inc., 120 West 31st St., New York 1, 1962.

THE DYNASTY. A Medical Novel by Charles H. Knickerbocker. 416 pp. $4.50. Doubleday & Co., Inc., Garden City, N.Y., 1962.

DOCTORS' DILEMMAS by Louis Lasagna, M.D. 306 pp. $4.95. Harper & Brothers, 49 East 33rd St., New York 16, 1962.

ATLAS OF CLINICAL ENDOCRINOLOGY. Including Test of Diagnosis and Treatment by H. Lisser, A.B., M.D., and Roberto F. Escamilla, A.B., M.D. 2nd ed. 489 pp. illus. $23.00. The C. V. Mosby Co., 3207 Washington Blvd., St. Louis 3, 1962.

AN ATLAS OF HEAD AND NECK SURGERY by John M. Loré, Jr., M.D., F.A.C.S. Illustrated by Robert Wabnitz. 490 pp. illus. $25.00. W. B. Saunders Co., West Washington Sq., Philadelphia 5, 1962.

PHYSICAL DIAGNOSIS by Ralph H. Major, M.D. and Mahlon H. Delp, M.D. 6th ed. 355 pp. illus. $7.50. W. B. Saunders Co., West Washington Sq., Philadelphia 5, 1962.

MAYO CLINIC DIET MANUAL by the Committee on Dietetics of the Mayo Clinic. 3rd ed. 222 pp. $5.50. W. B. Saunders Co., West Washington Sq., Philadelphia 5, 1961.

MEDICAL GENETICS 1958-1960. An Annotated Review by Victor A. McKusick, M.D. and Contributors. 534 pp. illus. $14.50. The C. V. Mosby Co., 3207 Washington Blvd., St. Louis 3, 1961.

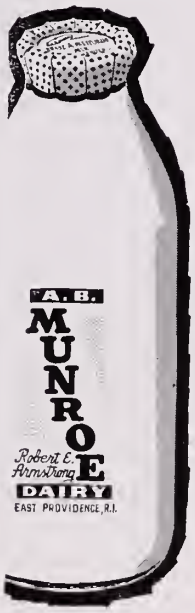
HEALTH EDUCATION. A Guide for Teachers and a Text for Teacher Education. Project of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association with the Cooperation of Contributors and Consultants. Edited by: Bernice R. Moss, ED.D., Editor; Warren Southworth, DR.P.H., Associate Editor, and John Lester Reichert, M.D., Associate Editor. 5th ed. 429 pp. illus. $5.00. National Education Association of the United States, 1201 Sixteenth St., N.W., Washington 6, D.C., 1961.

Oakes' *DICTIONARY FOR NURSES.* Compiled by Nancy Roper, S.R.N., R.S.C.N., S.T.D. (Lond.) 11th ed. 492 pp. illus. E. & S. Livingstone Ltd., Edin. & Lond., 1961; Williams &

concluded on next page

AS CLEAN
AS MODERN
DAIRY SCIENCE
CAN MAKE IT...





The A. B. Munroe Dairy Laboratory, where milk is subjected to constant testing, using the most modern methods of milk analysis.

Through every step in processing, from the immaculate receiving room to pasteurizing and homogenizing, on through bottling and refrigeration, the A. B. Munroe Dairy observes the strictest standards of dairy hygiene. The spotless surroundings and rigid quality control are so designed that all A. B. Munroe Dairy products that reach your table are as fresh, wholesome and pure as modern science can make them.



A. B. MUNROE DAIRY, INC.
151 Brow Street, East Providence, Rhode Island

Call GE 8-4450
for Home Delivery

Wilkins Co., 428 E. Preston St., Baltimore 2, 1961.

EARLY DETECTION AND DIAGNOSIS OF CANCER by Walter E. O'Donnell, M.D.; Emerson Day, M.D., F.A.C.P. and Louis Venet, M.D., F.A.C.S. Drawings by Shirley Baty. 286 pp. illus. $12.00. The C. V. Mosby Co., 3207 Washington Blvd., St. Louis 3, 1962.

TREATMENT OF INJURIES TO ATHLETES by Don H. O'Donoghue, M.D. 649 pp. illus. $18.50. W. B. Saunders Co., West Washington Sq., Philadelphia 5, 1962.

A TEXTBOOK OF OBSTETRICS by Duncan E. Reid, M.D. Illustrated by Edith Tagrin. 1087 pp. illus. $18.50. W. B. Saunders Co., West Washington Sq., Philadelphia 5, 1962.

PSYCHOCHEMOTHERAPY. The Physician's Manual by Edmund Remmen, M.D.; Sidney Cohen, M.D.; Keith S. Ditman, M.D., and John Russell Frantz, M.D. 152 pp. illus. $4.50. Western Medical Publications, 1721 W. Olympic Blvd., Los Angeles 15, 1962.

THORACIC DISEASES. Emphasizing Cardiopulmonary Relationships by Eli H. Rubin, M.D., F.A.C.P., F.C.C.P. and Morris Rubin, M.D., F.A.C.S., F.C.C.P. In Association with George C. Leiner, M.D., F.A.C.P., F.A.C.C. and Doris J. W. Escher, M.D. 968 pp. illus. $25.00. W. B. Saunders Co., West Washington Sq., Philadelphia 5, 1961.

A TRAVELER'S GUIDE TO GOOD HEALTH by Colter Rule, M.D. Dolphin Books. 240 pp. 95¢. Doubleday & Co., Inc., Garden City, N.Y., 1961.

FINANCING MEDICAL CARE. An Appraisal of Foreign Programs by Various Authors. Helmut Schoeck, Editor. The Caxton Printers, Ltd., Caldwell, Idaho, 1962.

TOMORROW'S MIRACLE by Frank G. Slaughter. 306 pp. $3.95. Doubleday & Co., Inc., Garden City, N.Y., 1962.

DR. MARY WALKER. The Little Lady in Pants by Charles McCool Snyder. 166 pp. illus. $3.95. Vantage Press, Inc., 120 W. 31st St., New York 1, 1962.

CLINICAL OBSTETRICS by Benjamin Tenney, M.D. and Brian Little, M.D., F.R.C.S. (C). 440 pp. illus. $8.50. W. B. Saunders Co., West Washington Sq., Philadelphia 5, 1961.

INTERNAL MEDICINE IN WORLD WAR II. Vol. I. Activities of Medical Consultants. Prepared and Published Under the Direction of Lieutenant General Leonard D. Heaton, the Surgeon General, United States Army. Editor in Chief, Colonel John Boyd Coates, Jr., M.C. Editor for Internal Medicine, W. Paul Havens, Jr., M.D. Office of the Surgeon General, Department of the Army, Washington, D.C. 880 pp. illus. $7.50. 1961.

BETWEEN US WOMEN. A Woman Doctor's Handbook on Pregnancy and Birth by Dr. Laura E. Weber. 153 pp. illus. $1.95. Doubleday & Co., Inc., Garden City, N.Y., 1962.



Wherever you go forget your telephone calls. We'll take them for you, day or night.

MEDICAL BUREAU

of the

Providence Medical Association



after surgery: vitamins are therapy

utritional supplementation is basic to postoperative care. herapeutic allowances of B and C vitamins help meet ncreased metabolic requirements and compensate for tress depletion. STRESSCAPS can set the patient on a nore favorable course and contribute to full recovery. ackaged in decorative "reminder" jars of 30 and 100.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

EDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y. Lederle

STRESSCAPS®

Stress Formula Vitamins Lederle

BRIEFS

FROM THE PHYSICIANS SERVICE PLAN OF
THE RHODE ISLAND MEDICAL SOCIETY

ATTENTION DOCTORS...
AND PATIENTS TOO!

Special Rates For Students
Now Available Under
Blue Cross And Physicians Service

WHO CAN QUALIFY?

Full-time students up to age 24 are eligible to join. This includes students attending high school. a technical or specialized school, or college. (Of course. unmarried children under age 19 are automatically covered under a family membership)

Undoubtedly some of your patients — either as students, or as parents who provide health care protection for their student children — qualify to take advantage of this low-cost protection.

IT'S EASY TO JOIN:

For more information and an application form, call or write the Blue Cross-Physicians Service Direct Pay Department.

ACT NOW!

This program is offered only once each year.

31 CANAL ST., PROVIDENCE 1, RHODE ISLAND • PHONE: TEMPLE 1-7300

OCTOBER, 1962

RHODE ISLAND

Medical Journal

Test All Patients for Diabetes
November 11-17, 1962
Diabetes Detection Week

Volume XLV, No. 10
Table of Contents, page 491

NEW YORK ACADEMY OF MEDICINE
NOV - 8 1962
LIBRARY



sign of infection?



symbol of therapy!

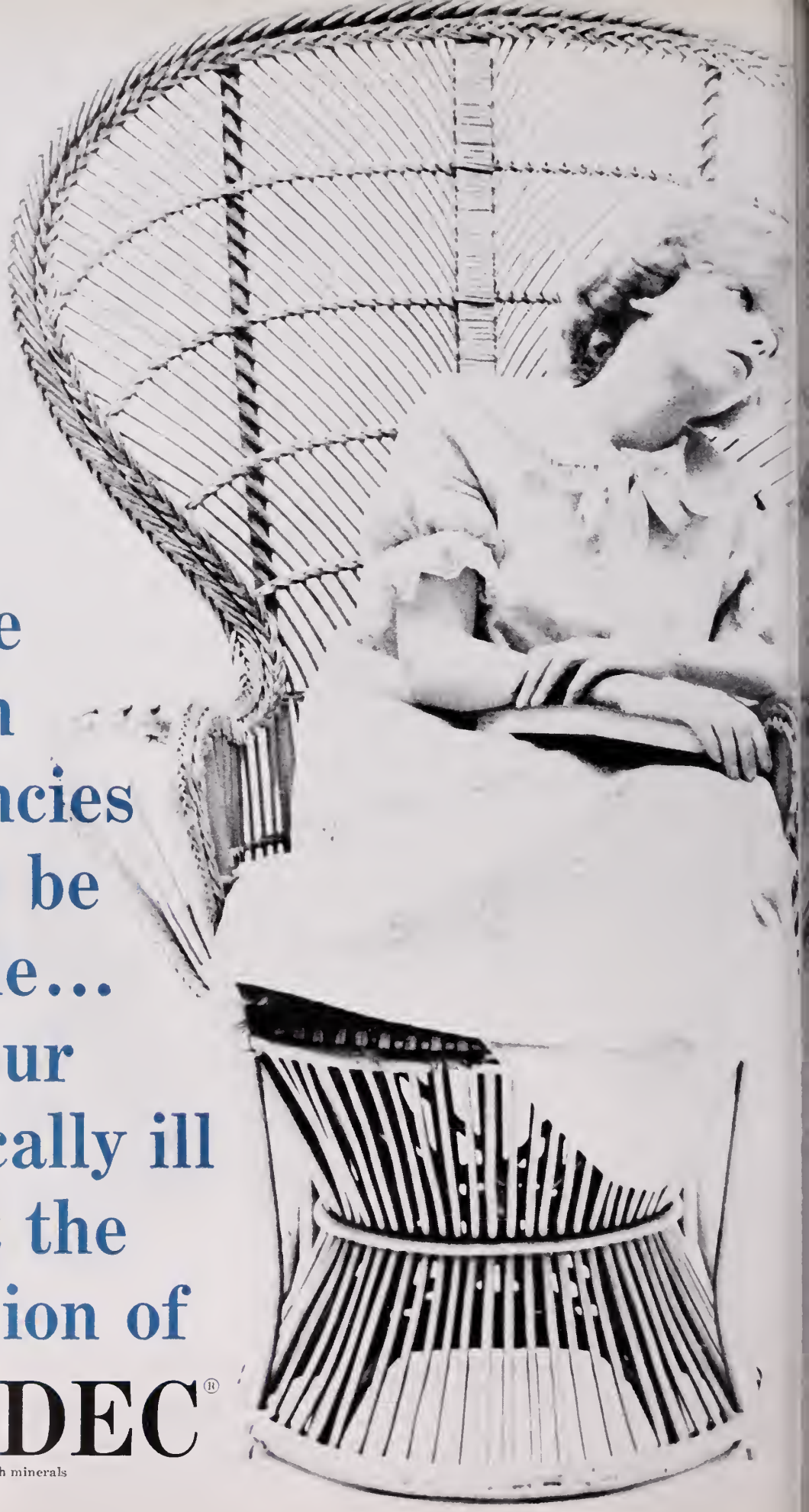
Ilosone® is available in three convenient forms: Pulvules®—125 and 250 mg.*; Oral Suspension—125 mg.* per 5-cc. teaspoonful; and Drops—5 mg.* per drop, with dropper calibrated at 25 and 50 mg.

This is a reminder advertisement. For adequate information for use, please consult manufacturer's literature. Eli Lilly and Company, Indianapolis 6, Indiana. Ilosone® (erythromycin estolate, Lilly) *Base equivalent

Lilly

232633

Ilosone works to speed recovery



because vitamin deficiencies tend to be multiple... give your chronically ill patient the protection of

MYADEC®

high-potency vitamin formula with minerals

It is generally accepted that diseases of long standing and other conditions of physiologic stress may produce a need for additional vitamins. MYADEC is designed to supply that need. Just one capsule a day provides therapeutic potencies of 9 vitamins, plus selected minerals normally present in body tissues. MYADEC is also useful for the *prevention* of vitamin deficiencies in patients whose usual diets are lacking in these important food factors.

Each MYADEC capsule contains: *Vitamins:* Vitamin B_{12}, crystalline—5 mcg.; Vitamin B_2 (riboflavin)—10 mg.; Vitamin B_6 (pyridoxine hydrochloride)—2 mg.; Vitamin B_1 mononitrate—10 mg.; Nicotinamide (niacinamide)—100 mg.; Vitamin C (ascorbic acid)—150 mg.; Vitamin A—(7.5 mg.) 25,000 units; Vitamin D—(25 mcg.) 1,000 units; Vitamin E (*d*-alpha-tocopheryl acetate concentrate)—5 I.U. *Minerals* (as inorganic salts): Iodine—0.15 mg.; Manganese—1 mg.; Cobalt—0.1 mg.; Potassium—5 mg.; Molybdenum—0.2 mg.; Iron—15 mg.; Copper—1 mg.; Zinc—1.5 mg.; Magnesium—6 mg.; Calcium—105 mg.; Phosphorus—80 mg. Bottles of 30, 100, and 250.

83562

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit 32, Michigan

BRIEFS

FROM THE PHYSICIANS SERVICE PLAN OF
THE RHODE ISLAND MEDICAL SOCIETY

New Contracts . . . Membership Up . . . "Open" Enrollment . . . Speakers & Leaflets Available.

Subscriber contracts revised . . . effective October 1. Now includes a "subrogation" clause. whereby plans can recover from responsible third parties. Copies of contract have been mailed to doctors . . . extra copies available on request.

602,000 Rhode Islanders are members of Physicians Service now . . . a new all-time high in membership. National Blue Shield enrollment is also rising — up two million persons over last year. for new high of over 50.000.000 persons.

Enrollment Open . . . October 15th to November 15th. Local plans to support National Blue Cross-Blue Shield effort to enroll aged. In Rhode Island. all persons can join during this period — regardless of age. physical condition or employment status. Memberships will become effective December 1st.

Speakers Available . . . for clubs and groups . . . to talk about the health plans — a current subject of interest to all audiences. For details. call or write.

49,000 copies of Physicians Service leaflet distributed . . . through doctor's offices, groups. etc. . . . leaflet explains what Physicians Service covers — and what is *not* covered. For a supply. call or write the plan office.

31 CANAL ST., PROVIDENCE 1, RHODE ISLAND • PHONE: TEMPLE 1-7300

The RHODE ISLAND MEDICAL JOURNAL

Editorial and Business Office: 106 Francis Street, Providence, R. I.

Editor-in-Chief: SEEBERT J. GOLDOWSKY, M.D.

Managing Editor: JOHN E. FARRELL, SC.D.

Senior Editors

ALEX M. BURGESS, SR., M.D. HENRI E. GAUTHIER, M.D.

Advisory Board

(in addition to editors listed above)

JOHN A. DILLON, M.D. JOHN F. W. GILMAN, M.D. ROBERT V. LEWIS, M.D.
PETER L. MATHIEU, M.D. JOSÉ M. RAMOS, M.D. ROBERT W. RIEMER, M.D.
JACK SAVRAN, M.D. LESTER L. VARGAS, M.D.

Owned and Published Monthly by
THE RHODE ISLAND MEDICAL SOCIETY
Second-class postage paid at Providence, Rhode Island

Copyright, 1962, the Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island
Single copies, 25 cents . . . Subscription, $2.00 per year.

Volume XLV, No. 10 October, 1962

TABLE OF CONTENTS

PAGE

THE COST OF DOING BUSINESS, *Orland F. Smith*, M.D., AND *Thomas J. Holland, Jr.* 505

HERNIA OF THE LINEA SEMILUNARIS (SPIGELIAN HERNIA), A Case Report, *Edward H. Smith*, M.D., AND *Edward V. Famiglietti*, M.D. 509

COMMON LESIONS WITH NEUROSURGICAL IMPLICATIONS APPEARING IN THE NEWBORN, *Walter C. Cotter*, M.D. 511

JEJUNAL DIVERTICULITIS WITH PERFORATION AND PERITONITIS, A Case Report and Review of the Literature, *Leonard J. Triedman*, M.D., AND *Albert F. Tetreault*, M.D. 516

EDITORIALS

Tuberculin Testing Programs 519
Some Doubts About the "Silent Spring" 519
How to Properly Split Infinitives 520
Happy New Year! 521
The A.M.A. Student Loan Fund 521

DEPARTMENTS

The Washington Scene 492
Through the Microscope 522
Book Reviews 528
Rhode Island Department of Health — Provisional Vital Statistics 532
On the Medical Library Bookshelves 534

MISCELLANEOUS

Have You a Taxpayer-Identifying Number? 498
A Modern Roman Circus 531

THE WASHINGTON SCENE

A Summary Report Prepared by the Washington Office of the American Medical Association

A SPECIAL ADVISORY COMMITTEE reported to the Public Health Service that the occurrence of 12 cases of polio among persons who had taken 38 million doses of oral vaccine did not provide any ground for questioning the safety of the live-virus vaccine.

Reporting on the study by the advisory committee, Doctor Luther L. Terry, Surgeon General of the PHS, said:

"Following administration of more than 38 million doses of oral vaccine, only 12 cases, outside of the epidemic areas, including five from Oregon, have been reported which had their onset of illness within 30 days of vaccination.

"Although the number was very small in relation to the number given vaccine and the diagnosis in certain of these cases seems questionable, I decided to call together members of my advisory committee to examine in detail the diagnosis, laboratory studies, and epidemiological circumstances relating to each of the cases.

"The group met on two occasions, on August 9 and 16, and after careful consideration of the facts, concluded that it was not possible to establish that the vaccine virus caused any of the cases. The advisers emphasized that polio viruses, as well as other viruses, are frequently present in the community and that it can be anticipated that occasionally poliomyelitis or illnesses simulating it may occur during or following vaccination programs. Illness and injury completely unrelated to polio and naturally occurring cases of polio have continued and, no doubt, will continue to be attributed to the vaccines. Furthermore, it is well known and recognized that any effective medication administered to millions of persons will cause or appear to cause a number of side effects.

"The committee, in summary, urged the continuation of present and projected programs of immunization looking toward the final elimination of the disease."

As of August 11, the approximate midpoint of the polio season, 274 cases of paralytic polio had been reported. The total, of which 129 cases were in Texas where outbreaks of type I had been occurring, was the same as for a comparable period last year.

* * *

Life expectancy at birth reached an estimated 70.2 years in the United States in 1961, according to the Public Health Service.

The estimate was based on a 10 per cent sample of death records received by the National Vital Statistics Division from all the 50 states.

Deaths totaled about 1,702,000 in 1961 — a rate of 9.3 per 1,000 population, only slightly higher than the record low rate of 9.2 for 1954.

Five of 10 leading causes of death showed sharp rate declines as compared with last year. The declines were large enough to make it improbable that they were produced by normal fluctuations due to sampling. The five were vascular lesions; accidents; influenza and pneumonia, except of newborn; general arteriosclerosis, and diabetes mellitus.

The infant mortality rate of 25.3 per 1,000 live births set a record low, about two per cent under the previous low of 25.7 recorded in 1960.

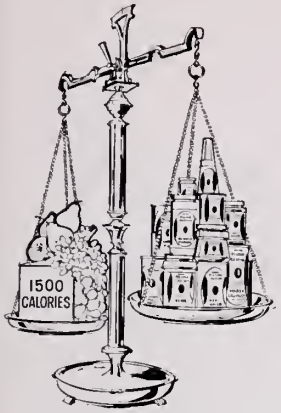
Recent statements that citizens of some foreign countries are healthier than Americans was disputed emphatically by the American Medical Association. The A.M.A. statement was prompted by a paper presented at the recent annual meeting of the American Sociological Association in Washington. The paper said that the United States is not as "healthy" as Sweden and England.

"This is like trying to compare apples to oranges," F. J. L. Blasingame, M.D., the A.M.A.'s Executive Vice President, said.

"There have been accounts that comparisons of a nation's over-all health can be made on the basis of life expectancy — that the people of Sweden and Britain are healthier because they live longer on the average than Americans.

"This proves nothing, for what you are actually comparing are differences in the makeup of populations. Both of these nations have small, stable, homogeneous populations, whereas that of the United States is a vast mixing from practically every conceivable corner of the globe, including all nationalities and races. . . .

"What you can prove statistically is that a person of Swedish descent in Minnesota lives longer than a Swede in Sweden, and that Mexicans apparently live longer in New Mexico than they do in Mexico. . . .



How to get patients to follow your directions for weight control...easily

60 DELICIOUS FOODS THAT CUT CALORIES, FAT AND CARBOHYDRATES!

How often do you sit across the desk from a patient whose problem is overweight, and wonder whether the directions you give for diet will be followed accurately—or at all?

A pleasant and efficient solution to this problem is to recommend the new Mott's Figure Control Foods. This line of over 60 different items has been developed through the latest scientific knowledge in the field of nutrition—and provides foods lower in calories by an average of 50%. Figure Control Foods take the guesswork out of menu-planning. Calorie cutting can be made pleasant and accurate, while eating normal-size portions of the kinds of food people enjoy every day at breakfast, lunch and dinner.

Low carbohydrate, low fat: Meat products have most of the hard fats removed (these are the saturated type) in a way that cannot be done at home. Sauces and dressings are prepared with a high proportion of non-fat milk solids, vegetable colloids; all are delicious and appetizing. Fruits, juices, desserts and sauces are prepared with non-caloric sweetener—natural fruit values are intact.

The carbohydrate, protein and fat content appears on each label, along with calorie counts. Useful for diabetics, too.

Easy medical tool for doctors: No possible dangerous side effects, not even temporary dislocation of meal patterns. Figure Control Foods in supermarkets include: Soups, Meats, Poultry, Sauces, Salad Dressings, Preserves, Syrup, Fruits, Drinks, Desserts, Sweeteners.

New Mott's Figure Control® Foods offer Good Eating at Half the Usual Calories

	Quantity	Figure Control Calories	"Regular" Food Calories
Apple-Grape Drink	½ cup	20	52
Five-Fruit Juice Breakfast Drink	½ cup	20	52
Braised Beef and Vegetables	6½ oz.	184	380
Meat Balls in Brown Gravy	3½ oz.	84	280
Chopped Chicken Livers	1 oz.	31	100
Chicken a la King	3 oz.	72	230
French Style Dressing	1 tbsp.	10½	60
Brown Gravy	1 tbsp.	7	21
Applesauce	½ cup	48	90
Fruit Cocktail	½ cup	44	90
Cherry Pie Filling	1 oz.	20	60
Chocolate Topping	1 tbsp.	8	63
Preserves (Peach, Strawberry)	1 tbsp.	9	55
"Maplette" Syrup	1 tbsp.	9	55
Liquid or Powder Sweetener	(to equal 1 tbsp. of sugar)	0	16



Complete menus, recipes, calorie chart available for professional distribution, with weight control guides you can distribute with confidence: all menus meet N.R.C. Recommended Daily Allowances. **Use this handy order form:**

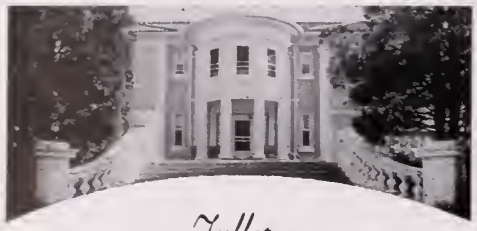
FIGURE CONTROL FOODS
Duffy-Mott Company
370 Lexington Avenue
New York 17, New York

Please send____free copies of YOUR WEIGHT CONTROL PLAN for use with patients.

Dr._____

Address:_____

City:_____ Zone:____ State:_____



Fuller

Memorial Sanitarium

Located on Rt. 1

South Attleboro, Massachusetts

A modern non-profit hospital for the care and treatment of nervous and emotional disorders as well as long term geriatric problems.

Physical, neurological, psychiatric and psychological examinations.

Modern recognized psychiatric therapies.

A pleasant homelike atmosphere in a beautiful and conveniently located institution.

L. A. Senseman, M.D., F.A.P.A., Medical Director
Edwin Dunlop, M.D. Michael G. Touloumtzis, M.A.
Oliver S. Lindberg, M.D. William H. Dunn, M.S.W.
W. H. Lesovsky, M.D., Ph.D.

Referred patients are seen daily (except Saturdays) 9-12 A.M., and by appointment.
R. I. Blue Cross Benefits Tel. Southgate 1-8500

Special Rates for Long-Term Care





Wherever you go forget your telephone calls. We'll take them for you, day or night.

MEDICAL BUREAU

of the

Providence Medical Association

asthma attack averted
. . . in minutes

patient protected
. . . for hours





Nephenalin®

(the dual-action anti-asthmatic tablet)

. . . works with nebulizer speed—provides four-hour protection

One NEPHENALIN tablet provides: *air in a hurry*—through sublingual isoproterenol HCl, 10 mg. *air for hours*—through theophylline, 2 gr.; ephedrine, 3/8 gr.; phenobarbital, 1/8 gr.

Dosage: Hold one NEPHENALIN tablet under the tongue for five minutes to abort the asthmatic attack promptly. Then swallow the tablet core for four full hours' protection against further attack. Only one tablet should be taken every four hours. No more than five tablets in 24 hours.

Supplied: Bottles of 50 tablets. For children: NEPHENALIN Pediatric, bottles of 50 tablets.

Caution: Do not administer NEPHENALIN with epinephrine. The two medications may be alternated at 4-hour intervals. NEPHENALIN should be administered with caution to patients with hyperthyroidism, acute coronary disease, cardiac asthma, limited cardiac reserve, acute myocardial damage, and to those hypersensitive to sympathomimetic amines. Phenobarbital may be habit forming. THOS. LEEMING & CO., INC., New York 17, N.Y.



Now Available for Rent . . . Pawtucket's Newest Professional Building

DARLINGTON PROFESSIONAL BUILDING

1499 NEWPORT AVENUE (NEAR MASSACHUSETTS STATE LINE)

Four Attractive Suites, each having 5 Spacious Rooms plus Lavette. Designed for the Medical Profession. Provisions for Medical and Dental Laboratories Available.

AMPLE OFFSTREET PARKING

For complete information write: Mr. Roger L. Messier, or call PA 5-0451



Coca-Cola, too, is compatible with a well balanced diet. As a pure, wholesome drink, it provides a bit of quick energy . . . brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE-MARK ®

NEW **SPECIAL COUGH FORMULA** *for Children*

Pediacof

Trademark

SOOTHING DECONGESTANT AND EXPECTORANT

Each teaspoon (5 cc.) contains:

Codeine phosphate	5.0	mg.
Neo-Synephrine® hydrochloride (brand of phenylephrine hydrochloride)	2.5	mg.
Chlorpheniramine maleate	0.75	mg.
Potassium iodide	75.0	mg.



Bright red, pleasant tasting, raspberry flavored syrup

Dosage:

Children from 6 months to 1 year, 1/4 teaspoon; 1 to 3 years, 1/2 to 1 teaspoon; 3 to 6 years, 1 to 2 teaspoons; 6 to 12 years, 2 teaspoons. Every four to six hours as needed.

How Supplied:
Bottles of 16 fl. oz.

Exempt Narcotic

Winthrop LABORATORIES
New York 18, N Y

Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

HAVE YOU A TAXPAYER-IDENTIFYING NUMBER?

Highlights of the Regulations Requiring Taxpayer-Account Numbers as Prepared by the Legal Department of the American Medical Association

UNDER AUTHORITY contained in Public Law 87-397 (Oct. 5, 1961), relating to taxpayer-identifying numbers necessitated by the installation of the automatic data processing system by the Internal Revenue Service, the Commissioner of Internal Revenue, on August 24, 1962, adopted regulations requiring taxpayers and payers of income to obtain and use identifying numbers. The regulations term the number prescribed for use by an individual an "account number." Since 140 million Americans already have Social Security numbers, it was decided to use these numbers to avoid the inconvenience of obtaining other numbers. Thus, the account number which an individual will indicate on a return or other related document will also be his Social Security number.

Unless a physician is or was ever an "employee," it is unlikely that he will have a Social Security number since doctors of medicine who are self-employed are excluded from coverage under the Social Security system. However, since *every* person required to make a return, statement, or other document for any period commencing after 1961 with respect to his tax liability, must have an account number, physicians will have to obtain such numbers even though they are not covered under the Social Security system.

According to the regulations, application forms for use in obtaining account numbers will as far as possible be furnished *without* request during 1962 to taxpayers needing numbers. Thus, a taxpayer is not required to file an application for an account number during 1962 *unless* furnished with an application. A taxpayer who has been supplied with an application form *must* file it in accordance with the instructions for such form. *After* 1962, an individual needing an account number *must* file an application for an account number on either Form SS-5 or Form 3227. An application form may be obtained from any District Director, or any District Office of the Social Security Administration.

An individual engaged in a trade or business is also required to obtain an identifying number which is termed an "employer identification number." For this (and our) purpose, an individual is considered to be engaged in a trade or business if any return is required to be filed by him as an employer (other than a household employer) with respect to his liability for the Social Security taxes imposed under the Federal Insurance Contributions Act and the provisions of the Internal Revenue Code which require an employer to withhold income taxes from the wages of employees. Thus, such an individual may not only have an account number but an employer identification number. And, under the regulations he is required not only to include his account number in the appropriate return, statement or other document but also to include his employer identification number in the schedule provided for reflecting profit or loss from a business or profession.

Obviously, a physician-employer is required to obtain an employer identification number if he doesn't already have one. This is unlikely if he has been an employer for some time. If a number has not been assigned then application therefor must be made on Form SS-4 to any District Director or any District Office of the Social Security Administration office. Referring to the requirement as to the inclusion of account numbers and employer identification numbers, a physician employer would have to include his account number on his income tax return (or declaration of estimated income tax) and his employer identification number on Schedule C of Form 1040 (Profit [or Loss] from Business or Profession).

An income tax return or a declaration of estimated income tax filed jointly by a husband and wife need include only the account number of the husband. However, a wife's account number must also be shown if, for the taxable year covered by the return or declaration, the wife has (a) separate gross income of $600 or more, or $1,200 or more if she has attained the age of 65 before the close of the taxable year, (b) self-employment income, or (c) income (such as wages, dividends, or interest) paid to her otherwise than with her husband which the payer thereof is required to report on a return or statement of information.

The law and regulations impose a penalty for failure to include the identifying number in any return, statement, or other document, or when otherwise required. The penalty is $5 for each such failure.

RELIEVE THE COLD SUPPRESS THE COUGH WITH NEW

'EMPRAZIL-C'

TABLETS

ANTITUSSIVE ▪ DECONGESTANT ▪ ANALGESIC

Each tablet contains:

Codeine Phosphate*	15 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Acetophenetidin	150 mg.
Aspirin (Acetylsalicylic Acid)	200 mg.
Caffeine	30 mg.

*Warning—may be habit forming.

Complete literature available on request.

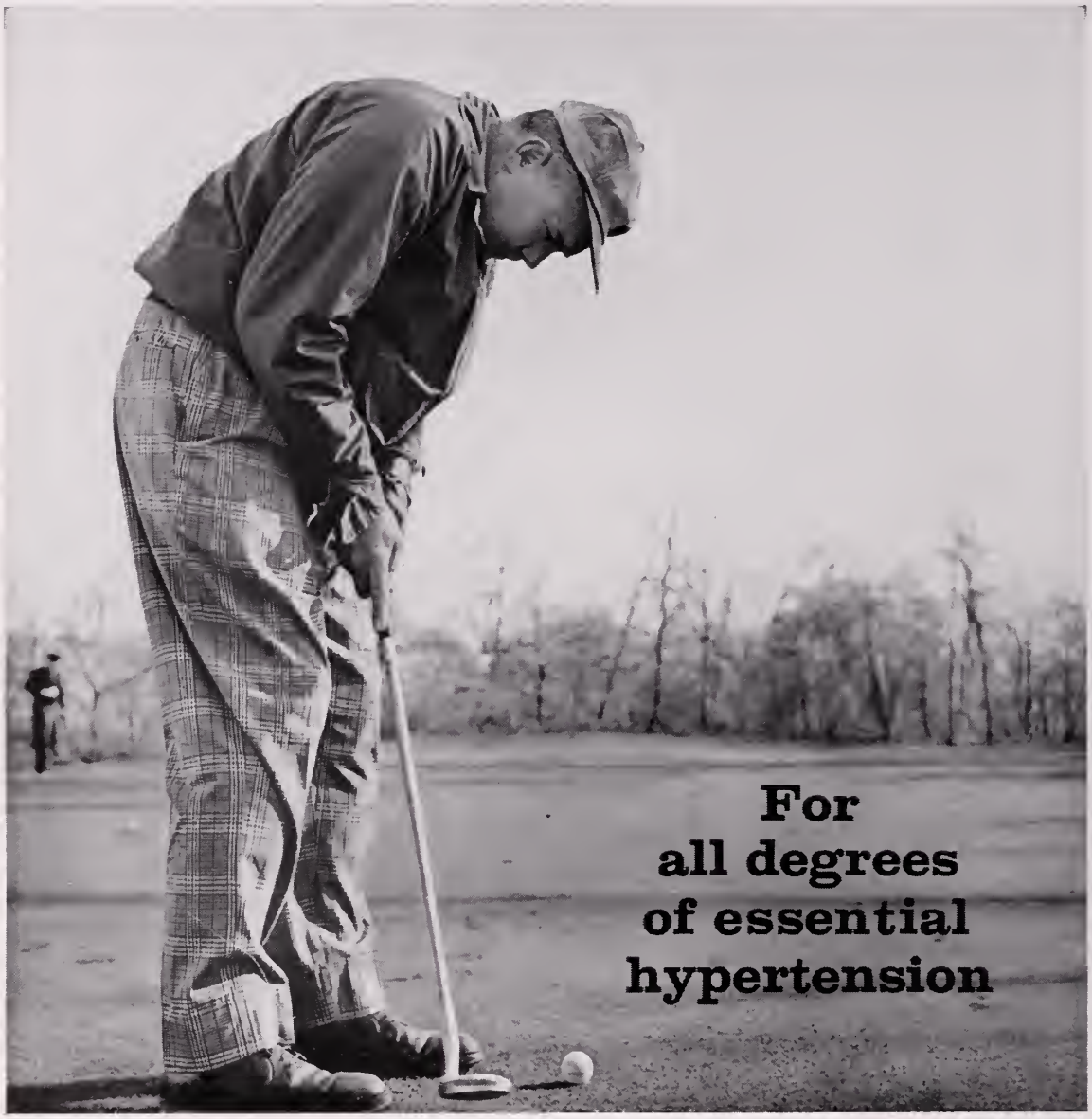
Also available without codeine as

'EMPRAZIL'®

TABLETS



BURROUGHS WELLCOME & CO. (U.S.A.) INC., TUCKAHOE, N.Y.



"relief of symptoms is striking with Rautrax-N"†

Rautrax-N decreases blood pressure for almost all patients with mild, moderate or severe essential hypertension. Rautrax-N also offers a new sense of relaxation and well-being in hypertension complicated by anxiety and tension. And in essential hypertension with edema and/or congestive heart failure, Rautrax-N achieves diuresis of sodium and chloride with minimal effects on potassium and other electrolytes.

Rautrax-N combines Raudixin (antihypertensive-tranquilizer) with Naturetin c̄ K (antihypertensive-diuretic) for greater antihypertensive effect and greater effectiveness in relief of hypertensive symptoms than produced by either component alone. Rautrax-N is also flexible (may be prescribed in place of Raudixin or Naturetin c̄ K) and economical (only 1 or 2 tablets for maintenance in most patients).

Supply: Rautrax-N — capsule-shaped tablets providing 50 mg. Raudixin, 4 mg. Naturetin and 400 mg. potassium chloride. *Rautrax-N Modified* — capsule-shaped tablets providing 50 mg. Raudixin, 2 mg. Naturetin and 400 mg. potassium chloride.

†Hutchison J. C.: Current Therap. Res. *2*:487 (Oct.) 1960.

For full information, see your Squibb Product Reference or Product Brief.

Rautrax-N*

Squibb Standardized Rauwolfia Serpentina Whole Root (Raudixin) and Bendroflumethiazide (*Naturetin) with Potassium Chloride

SQUIBB *Squibb Quality — the Priceless Ingredient*

SQUIBB DIVISION Olin

'RAUDIXIN'®, 'RAUTRAX'®, AND 'NATURETIN'® ARE SQUIBB TRADEMARKS.

consider
the convenience
to pregnant
women of
a tablet this size



ENGRAN

Squibb Vitamin-Mineral Prenatal Supplement

FORMULA SUPPLIES 45 MG. OF IRON – AT NO EXTRA COST

The size of a prenatal vitamin-supplement tablet is important—the nausea and gastric distress often associated with pregnancy may make swallowing *anything* a real problem. Hence the small size of the Engran tablet is a great convenience to your pregnant patient, for Engran is actually the *smallest* tablet now available for prenatal vitamin-mineral supplementation. Yet only *one Engran tablet* a day will provide all these vitamins and minerals to help assure a nutritionally perfect pregnancy –

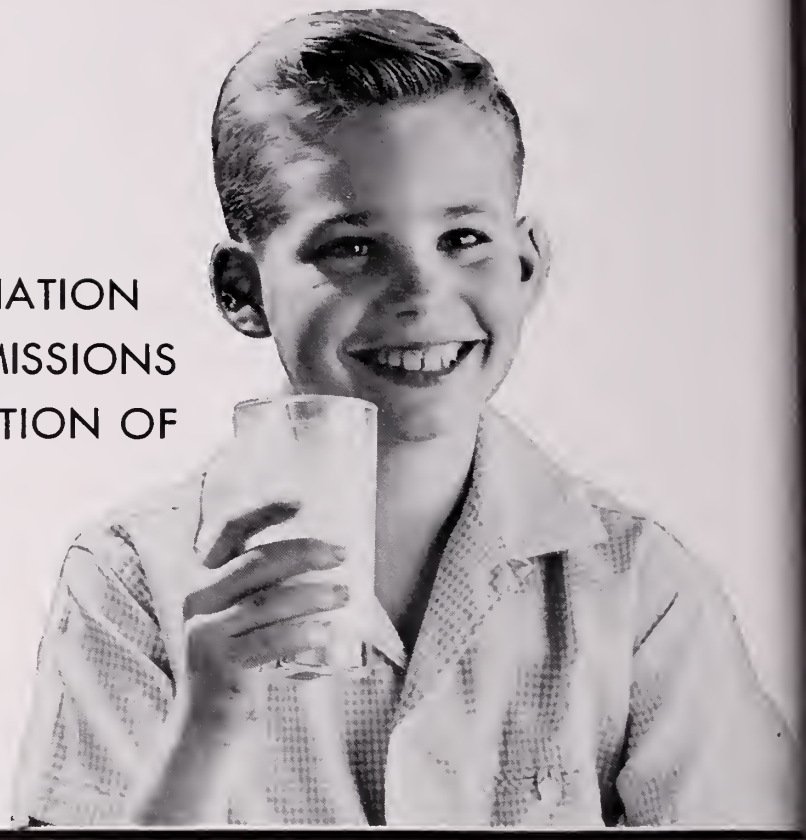
Vitamin A 5,000 U.S.P. units; vitamin D 500 U.S.P. units; thiamine 3 mg.; riboflavin 3 mg.; pyridoxine 2 mg.; vitamin B_{12} 2 mcg.; niacinamide 20 mg.; calcium pantothenate 5 mg.; vitamin C 75 mg.; calcium 100 mg.; iron 45 mg.; iodine 0.15 mg.; copper 1 mg.; magnesium 6 mg.; zinc 1.5 mg.; manganese 1 mg.

For full information see your Squibb Product Reference or Product Brief.

SQUIBB *Squibb Quality—the Priceless Ingredient*

SQUIBB DIVISION Olin

Engran® is a Squibb trademark



THE AMERICAN ASSOCIATION
OF MEDICAL MILK COMMISSIONS
SUPERVISES THE PRODUCTION OF

Certified MILK

1. CLEANER. Lowest bacteria-count. Milk checked before each milking. All utensils, bottles, and equipment sterilized before use.

2. BETTER-PROTECTED. Strictest medical supervision of herds and employees. Frequent examinations and laboratory-control AT THE FARM are required.

3. AUTOMATIC MILKING. Cows are milked automatically by electric machine. Milk is bottled without exposure to air or human touch.

4. BOTTLE CLOSURES. Must be of the highest quality to provide complete protection for the milk and bear approval of The American Association of Medical Milk Commissions.

5. MORE NUTRITIOUS. Cows scientifically fed balanced ration. Nutrition control from soil to delivery of milk. Same diet all year.

6. LONGER-LASTING, BETTER-TASTING. Diet control, special handling, and shortest time of delivery from cow to consumer assure fine fresh flavor that lasts for weeks.

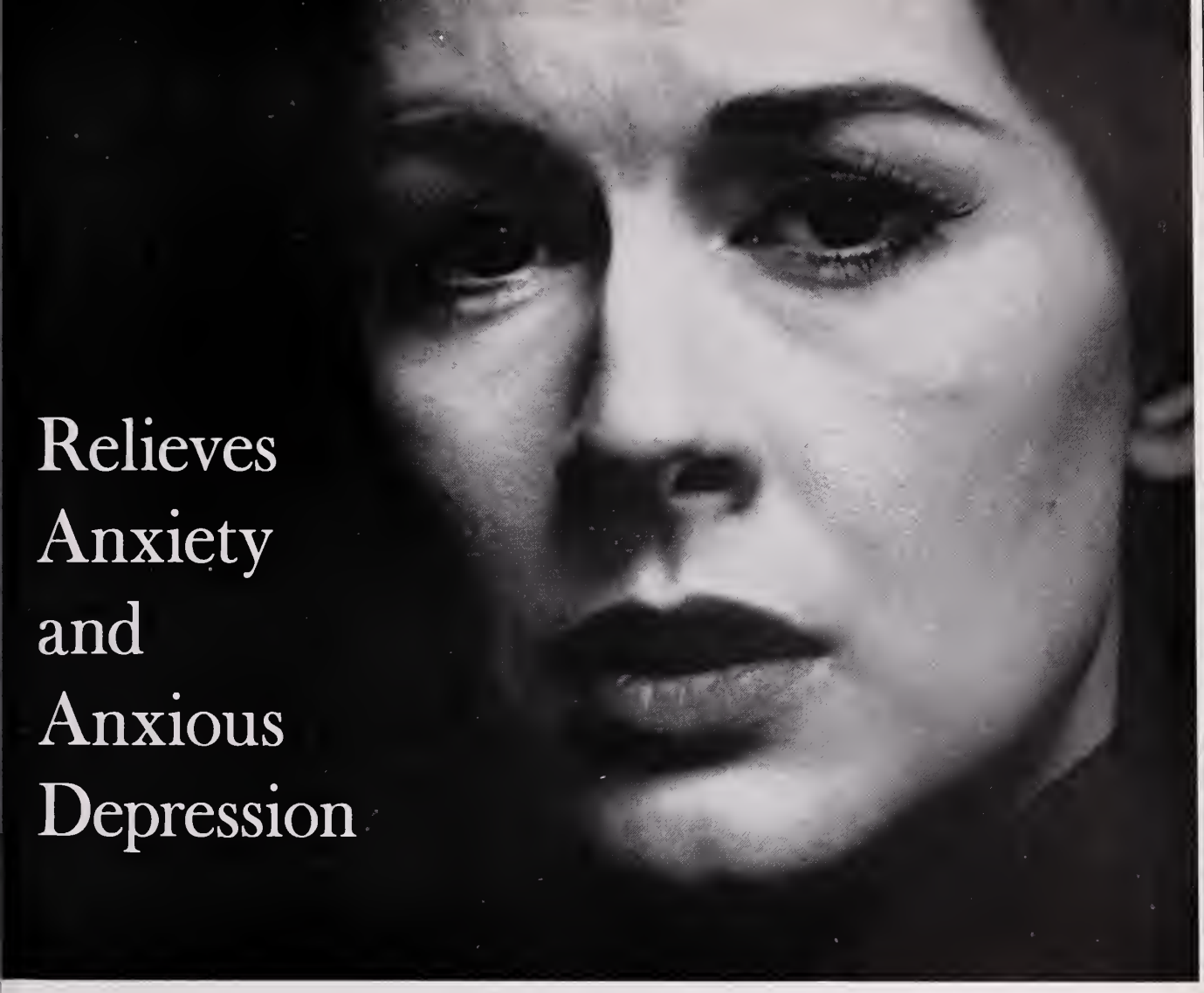
7. THE DOCTOR'S MILK. Produced, processed, bottled on farms supervised by Medical Milk Commissions. Each bottle bears the seal of the A.A.M.M.C. and names of the supervising Commission and producing farm.

MILK COMMISSION OF PROVIDENCE MEDICAL ASSOCIATION

HILLSIDE FARMS, INC., 1308 Phenix Ave., Cranston, WI 2-3400
Produced at Hillside Farm, Cranston, R. I.

H. P. HOOD & SONS, 135 Harris Ave., Providence, DE 1-3024
Produced at Hood Certified Farm, Beverly, Mass.

WHITING MILK CO., 40 Tockwotton St., Providence, GA 1-5363
Produced at Hampshire Hills Farm, Wilton, N. H.



Relieves Anxiety and Anxious Depression

The outstanding effectiveness and record of safety with which Miltown relieves anxiety and anxious depression—the type of depression in which either tension or nervousness or insomnia is a prominent symptom – has been clinically authenticated time and again during the past seven years. This, undoubtedly, is one reason why physicians still prescribe meprobamate more often than any other tranquilizer in the world.

Miltown®

meprobamate (Wallace)

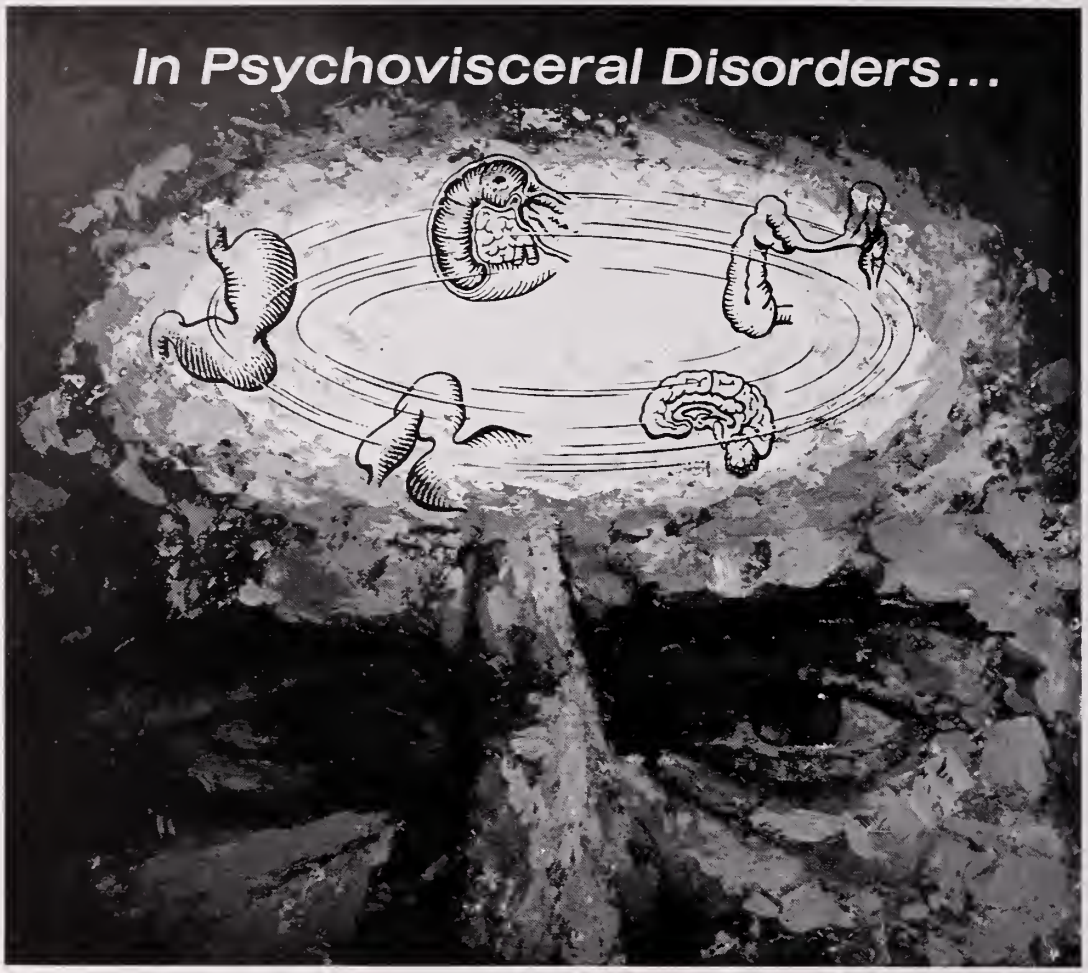
Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50. Also as MEPROTABS® – 400 mg. *unmarked*, coated tablets; and in *sustained-release* capsules as MEPROSPAN®-400 and MEPROSPAN®-200 (containing respectively 400 mg. and 200 mg. meprobamate).

WALLACE LABORATORIES / *Cranbury, N. J.*

Clinically proven in over 750 published studies

1. Acts dependably – without causing ataxia or altering sexual function
2. Does not produce Parkinson-like symptoms or liver damage
3. Does not muddle the mind or impair physical activity

CM-7381



...Autonomic Stability

PRO-BANTHĪNE® with DARTAL®

brand of propantheline bromide with thiopropazate dihydrochloride

The combination of PRO-BANTHĪNE with DARTAL provides an autonomic stabilizer of notable efficacy in common psychovisceral disorders.

DARTAL, a particularly well tolerated tranquilizer, allays the central nervous influence in such conditions as peptic ulcer, gastritis, pylorospasm, spastic constipation and mucous or ulcerative colitis. PRO-BANTHĪNE suppresses the emergence of hypersecretion and hypermotility in the stomach and intestines.

By alleviating excessive activity at both ends of the vagus, PRO-BANTHĪNE with DARTAL assures prompt, definite, sustained control not only of severe and persistent gastrointestinal dysfunctions but also of stress-aggravated episodes of more moderate conditions.

USUAL ADULT DOSAGE: One tablet three times a day.

SUPPLIED: Aqua-colored, compression-coated tablets containing 15 mg. of PRO-BANTHĪNE and 5 mg. of DARTAL.

G. D. SEARLE & CO.

CHICAGO 80, ILLINOIS

Research in the Service of Medicine

The RHODE ISLAND MEDICAL JOURNAL

VOL. XLV OCTOBER, 1962 NO. 10

THE COST OF DOING BUSINESS

ORLAND F. SMITH, M.D., AND THOMAS J. HOLLAND, JR.

The Authors. *Orland F. Smith, M.D., Surgeon-in-Chief, Pawtucket Memorial Hospital.*
Thomas J. Holland, Jr., President, Medical Management of Rhode Island.

INTRODUCTION

THE COST of doing business for the doctor is a very delicate subject. We embark upon this discussion with certain misgivings. Up to now no one has ever tried to determine or discuss such cost in a given locality from the point of view of either the doctor or the economist. The subject of the doctor and the money he is paid for his services has always been surrounded by a great deal of mystery. As medical care gets ever closer to being classified as a commodity through the medium of the fee schedule, it seems logical that we combine the efforts of the economist and the doctor in an effort to shed a little more light on the subject. The atmosphere needs clearing since the availability and quality of medical care are subject to the fundamental effects of profit and cost.

Almost everybody tries to understand the benefits of our Social Security system, and its shortcomings, privileges, and exclusions. Almost everybody tries to understand wages and hours, overtime and double time, the abundant life in America, and the grocery bill. A few try to understand the complex nature of national deficits and the political thinking of the major political parties. Most understand that their own personal life must be conducted on a break-even basis. Should they fail to understand anything so fundamental someone comes along and explains it all.

Almost everybody understands the high cost of the exacting discipline which leads to a medical degree, and the years of productive earning that are lost in the process. (The average specialist is about 32 years of age when his productive earning begins.)

No one, however, seems to know very much about the doctor's bill and can't even try to understand it, because the doctor won't talk. Everyone has heard much about it, mostly from authorities who don't seem to know much about it either, except that it is too big. These authorities have been challenged from time to time by various segments of the medical profession. Often these challenges haven't seemed to make much sense.

Frequent references are made to the Oath of Hippocrates, which was written twenty-five hundred years ago. Many of these references are made by spokesmen who have never read it. We think it may be well to reprint a common version of the Oath. When read in full one will note that there is no reference to either science or business, and that the entire text refers to the art of medicine as it was known then.

The Hippocratic Oath

I swear by Apollo the physician, and Esculapius, and Hygiea and Panacea and all the Gods and Goddesses, that according to my ability and judgment, I will keep this Oath and this stipulation — to reckon him who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others. I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practice my Art. I will not cut persons labouring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I

continued on next page

enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further, from the seduction of females or males, of freemen and slaves. Whatever in connection with my professional practice or not in connexion with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times! But should I trespass and violate this Oath, may the reverse be my lot!

The entire approach to the problems of medical care unquestionably needs a reappraisal: art, science and business need to be discussed all at the same time. As long as everyone else is talking about the dollars the doctor collects, he should be allowed to talk about them too, and not be summarily squelched by a quotation out of context from the Oath. This is what we have decided to do. The art of medicine needs very little discussion, except that today it seems to be synonymous with "bedside manner." The patient wants to know whether his doctor has enough knowledge of the science of his illness to get him well in the shortest possible time without forcing him into bankruptcy while doing it. If he doesn't seem to know how to do just that, the neighbors help out.

The entire discussion should be boiled down to a consideration of the competency of the doctor and his cost of doing business. In all of our discussions with politicians, labor leaders, and businessmen, as well as with doctors, there is an appalling ignorance of the business side of a medical practice. This is the problem that needs to be discussed by all parties regardless of their concern or of any ulterior motives.

A discussion of the method by which any business is conducted must be reduced to a common denominator that is sufficiently simple for everybody to understand. Such a discussion must mention the basic medium of exchange, and it should be sufficiently frank to inform even those who have passed a point where they feel they have much left to learn.

Statistical Study

In preparation for this discussion of the cost of doing business, a questionnaire was mailed to eight hundred and fifty doctors who practice in Rhode Island, asking for a complete breakdown of the individual costs for each of them. Knowing of the doctors' ingrained reticence to talk about money, we wondered if we were not embarking on a project that could fizzle out into an enormous waste of time and effort.

One hundred and fifty doctors were overlooked in the mailing. They included retired or semi-retired, full-time salaried personnel, new doctors who had not reached our list and a few who were inadvertently overlooked in the exchange of data. Two hundred and six replies were returned, or a sample of those asked of a little over 24 per cent. The results were most revealing.

The information was asked for on unsigned forms and the identity of the doctor was not known. Many doctors, however, did answer all of the questions and in addition wrote personal notes that added up to "It's about time someone did this." The statistical analysis of the entire sample has been completed along conventional lines, and the median cost of each item has been computed. Of the two hundred and six replies, 60 were from generalists and 146 from specialists, with no attempt to determine the nature of the specialty. This ratio compares favorably to the division of generalists and specialists who practice in Rhode Island. The state Medical Society records 316 generalists and 684 specialists in the entire state. A small error percentage could result from the number who were overlooked.

In the process of locating the "median" cost of each of the questions asked, an array was constructed for both groups. Each of the costs was listed and graphed in the order of increase by which it appeared. With the sixty generalists, therefore, the median cost of each item of expense appeared between the sums reported between the numbers 30 and 31. By the same method, the costs for the 146 specialists showed the "median" to be at the 73d point at which the greatest number of doctors appeared. Beyond the mid-point in such an array of listed costs, one can see that a decreasing number of doctors had an increasing cost and that the converse would be true leading to it. In those costs where all of the sample failed to report an answer, the "median" was taken at the halfway point of the number that did report. In this manner, the arithmetical average was ignored because of the obvious distortion which could result.

The questionnaire itself took the form of "Other Business Deductions" as reported on tax returns filed with the Internal Revenue Service in April, 1962. The "median" cost of the items appearing in the tax returns resulted in the following:

	GENERALISTS	SPECIALISTS
Schedule C-2	3000	4683
Salaries	3200	4000
Rent	1400	1800
Business Interest	175	250
Business Taxes	250	350
Depreciation	1200	1500
Repairs	250	275
Insurance	290	290
Legal & professional	75	150
Total	9840.00	13,298.00

Losses on business property were reported by such a small number of the total of each group that it has been disregarded.

Schedule C-2, one of the highest of all the costs includes the following items:

Electricity and gas
Telephone and answering service
Medical society and hospital staff dues
Office supplies
Medical journals
Laundry and uniforms
Maintenance, nursery and lawn care
Snow removal
Professional assistants
Professional entertainment
Gifts
Conventions and travel
Automobile expense
Stamps and postage
Water
Postgraduate courses
Heating and air-conditioning
Prepaid insurance for employees
Waiting and reception room equipment such as magazines, TV, music, etc.

Salaries varied considerably, depending, we presume, on the type of practice. Generally speaking, the larger the practice, the more employees would be needed to perform the various duties which can properly be delegated. Employees are listed as nurses, receptionists, secretaries, office aides, technicians, laboratory technologists, switchboard operators, librarians, and physiotherapists.

Rent needs very little discussion except to say that space occupied by a doctor as an office will command a price in excess of $3.50 per square foot per year. Rentals that are at a higher base obviously will include some of the items otherwise listed in Schedule C-2. The same amount of space occupied as living quarters will command an annual rent of a lesser amount.

Business interest, business taxes, depreciation, repairs, insurance, legal and professional costs are largely self-explanatory. As they make up the smaller portion of costs, they need no further elaboration.

These costs will undoubtedly startle many readers, more particularly those who have always thought that the dollars a doctor collects are all profit. A prominent newspaper has recently published the following statement: "Medical services, it seems to us, is not a commodity to be bought by the pound or the hour." This is undoubtedly true, and with this statement we are in hearty agreement. We do believe, however, that any such statement should be followed by a description of the mechanism by which they believe medical services should be priced as well as the basis by which the cost of doing business can be paid for, in order that quality and availability can be maintained at the same high standard which most people want and expect. Cost plus, dollars per week, dollars per patient per year have all been tried abroad with questionable success. How long it will take to arrive at a satisfactory formula in America may be found in the actuarial experience of the insurance companies that are doing so well in expanding the voluntary way. We surely believe that the true basis must be determined by including a little of the material that can be found in discussions such as this.

In addition to the questions listed above as having been asked in this questionnaire, the request was made for hours of work per week. The range went from eight hours for a semi-retired generalist to 116 hours for a busy specialist. The median for the generalists was 72 hours per week and 73⅓ hours for the specialist. Even though all the hours a doctor works each week are not productive of income directly, we are tempted to show what such long weeks of work as have been reported amount to in terms of dollars per hour just to pay the bills. This again is probably the easiest way to do it, as most of the costs are arrived at because someone is

concluded on next page

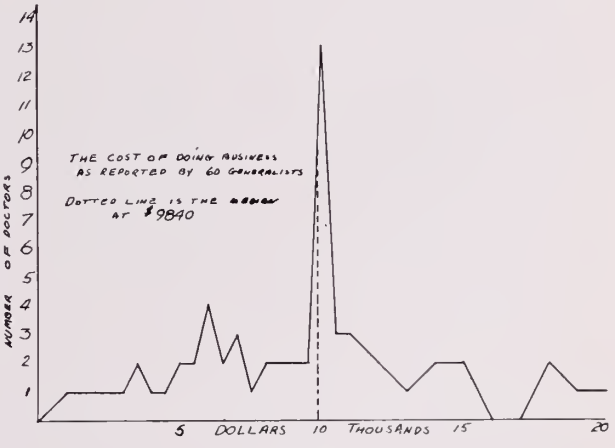


FIGURE 1

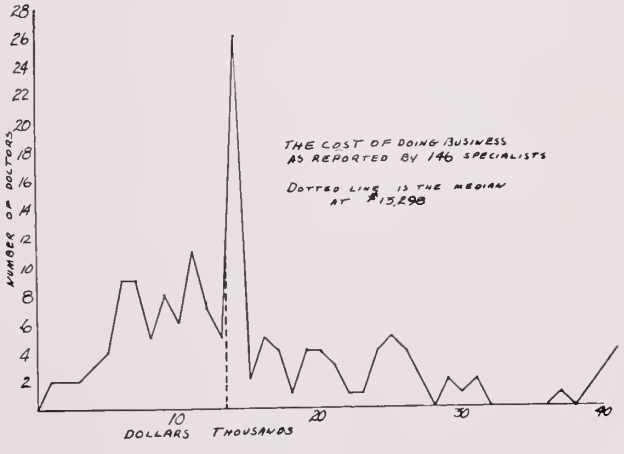


FIGURE 2

paid so many dollars per hour. With the "median" cost at $9840.00, the generalist who works 72 hours per week, must collect $2.62 per hour before his profit begins. For the specialist, the cost per hour for the same purpose amounts to $3.48. No provision is made for the doctor's vacation; these costs go on whether he is away or not, much the same as in any other business classified as a "sole proprietorship."

We are sure that at this point the interest of some of our readers has lagged a little. What they want to know is how much money the doctor collects in a year. In spite of the fact that many think this is a big mystery, the figures are readily available for those who really are sufficiently interested to look. The Internal Revenue Service publishes this information in statistical form in several different publications which are available from the U. S. Government Printing Office for a nominal charge. The last full year for which records are available is 1960. We must, therefore, take the liberty of assuming that the totals did not change much in the year, in order to make some kind of a comparison. The first publication lists a total of 405,673 businesses under *Medical and Other Health Services*. Of this number, 145,268 are listed as offices of physicians, surgeons, and oculists, or 35.8 per cent of the total. This 35.8 per cent receives 55 per cent of the total business receipts with a net profit of 58.5 per cent. The cost of doing business for physicians, surgeons, and oculists is therefore, 41.5 per cent of gross receipts, if he works as a "sole proprietor." The rest of the 55,000 doctors in the United States must obviously be listed in groups or employed in positions otherwise classified.

If these amounts are true for the state of Rhode Island, the general practitioner spends $9840.00 in costs from an income of $23,686.00. From the $13,846.00 that he has left, he pays interest and principal on his mortgage, personal real estate not used in his business, sales and personal property tax, together with contributions to his church, college, community fund and other charities. For the average family of four, these deductible items could amount to $1000.00 a year, an amount allowed unless he chooses to itemize. He then pays a quarterly tax of $578.99 for a total of $2315.96 per year. His net after taxes is therefore, $10,530.00 per year for which he works 72 hours a week for an average of $183.32 per week. If this were computed on a base pay scale with no fringes at all, one can see that with time and a half for work over 40 hours, he is working for a few pennies over $2.00 per hour.

The specialist fares a little better. He spends $13,298.00 on paying for costs of conducting his business from an income of $32,045.00. He pays the same other taxes as does the generalist. His family of four takes the same standard deduction of $1,000.00, and he pays an income tax of $931.00 per quarter or $3,724.00 per year. His net after taxes amounts to $14,023.00, and he is paid $269.00 per week, during which he works 73⅓ hours. He is, therefore, working for a few cents under $3.00 per hour after taxes, or computed on the 40-hour week plus overtime.

Finally it should be pointed out that paid holidays, vacations, basic hospitalization and health insurance, major medical, social security, cash sickness, temporary disability, life insurance and pension funds — just to name a few — are not available for the doctor unless he provides them for himself from net income after taxes.

Discussion

It is reasonable to conclude 206 doctors would develop a typical pattern for the entire state. A challenge may appear from both doctors and laymen who believe that they are thinking in terms of the public interest. To them we would say that a 24 per cent sample was quite gratifying; such a sample should be acceptable. To those who still insist that the doctor is an affluent member of society today, we would say look around. We would further sound a note of caution lest young people be discouraged from pursuing the exacting discipline of medicine by unthinking meddling in its economics.

References

[1]Form 1040 U. S. Internal Revenue Service
[2]Publication No. 453 (2-62) U. S. Treasury Department
[3]Statistics With Applications in Management and Economics: by Earl K. Bowen, Richard D. Irwin, Inc., Homewood, Ill., 1960

DO YOU KNOW?

- That it has been estimated that the cost of medicine dispensed by charlatans exceeds $1 billion a year in the United States.
- That quackery in the promotion of special dietary foods and supplements costs the American consumer $500 million a year.
- That a study by the Arthritis and Rheumatism Foundation found that quackery in the treatment of those diseases cost $250 million a year.
- That there are vendors who sell bottled sea water, at a cost of up to $20 a gallon, which is offered as a cure for virtually all human ailments.

New England Postgraduate Assembly

at Boston, Massachusetts

November 6, 7, 8, 1962

HERNIA OF THE LINEA SEMILUNARIS (SPIGELIAN HERNIA)

A Case Report*

EDWARD H. SMITH, M.D., AND EDWARD V. FAMIGLIETTI, M.D.

The Authors. *Edward H. Smith, M.D., Surgical Resident, and Edward V. Famiglietti, M.D., Associate Surgeon, Rhode Island Hospital, Providence, Rhode Island.*

A SPIGELIAN HERNIA (named after the Flemish anatomist, Adriaan van der Spieghel, 1578-1625) is a hernia that occurs in the linea semilunaris above the epigastric artery and generally at the linea semicircularis (Figure A). Above the linea semicircularis the rectus muscle is embraced by the split layers of the internal oblique muscle. The external oblique passes anteriorly, and the transversus abdominis muscle constitutes the deep layer. Caudal to the linea semicircularis the external oblique, internal oblique, and transversus pass anterior to the rectus muscle and the transversalis fascia passes posteriorly[1] (Figure B). This has led anatomists to postulate a congenital anatomic predisposition to herniation. Zimmerman, Anson, Morgan, and McVay[2] have demonstrated considerable anatomic variation in the banding of the abdominal muscles with resulting local areas of weakness that are potential sites of herniation. Others feel that, in addition, there is an acquired weakness of a portion of the transversus, or internal oblique, or both with resulting predisposition to the development of a hernia. Still others[3,4] believe that the small orifices of the perforating vessels are the predisposing factors.

Case Report

T. R., (#640603), a 65-year-old, widowed, white female entered the hospital July 12, 1960 with a three-year history of constipation requiring the frequent use of laxatives. Several days before admission, she noted obstipation and abdominal distension with cramps, and she had also experienced an episode of "bilious" vomiting.

Past history revealed an admission in 1942 for "intestinal trouble" and in 1947 for "intestinal obstruction due to constricting bands." In 1947 a preoperative note stated: "Doctor Mathews pointed out a mass in the left lower quadrant which moves and is not particularly tender. Presume this may have something to do with the etiology of the obstruction but don't know what it is." An excerpt from the operative note read: "Nubbin of intestine protruding through a band which extended from the sigmoid to the lateral peritoneal wall."

Physical examination revealed a well-developed, obese, hypertensive, white female in mild discomfort. The abdomen was markedly distended and tympanitic with hyperactive peristaltic sounds. A moderately tender left lower quadrant "prominence" was noted. Barium enema revealed an obstruction at the junction of the descending colon

concluded on next page

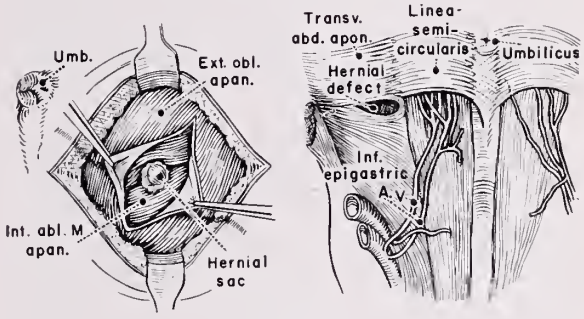


FIGURE A

The figure on the left demonstrates a left Spigelian hernia as it might appear at surgery. The figure on the right is a posterior view of the aponeurotic defect and the anatomic relationship. If the defect were below the inferior epigastric vessels, a herniation would be through Hesselbach's triangle and, therefore, a direct inguinal hernia.

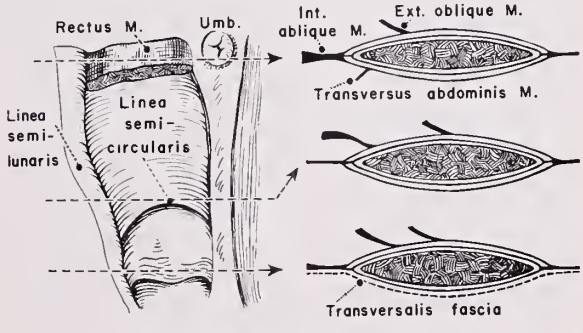


FIGURE B

Disposition of the fascial layer about the rectus muscle, rostral and caudal to the lineasemicircularis.

*From the Department of Surgery, Rhode Island Hospital, Providence, Rhode Island.

and sigmoid (Figures C). The possibility of Spigelian hernia was considered but could not be definitely confirmed by this study.

At operation a knuckle of sigmoid, which was in 180 degree clockwise torsion, was found incarcerated in a Spigelian hernia. The hernia was reduced, the sac excised, the redundant sigmoid resected, and the semilunar defect at the linea semicircularis was repaired.

The patient was discharged on the seventeenth hospital day after an essentially unremarkable convalescence only to return that afternoon because of increasingly severe right lower quadrant pain.





FIGURES C (a, b)
Barium enema studies.

On readmission an incarcerated cecum in a right Spigelian hernia was found. After reducing the cecum and performing an appendectomy, the hernia was repaired. She was discharged seven days later.

Comment

This case of hernia of the linea semilunaris (Spigelian hernia) is presented because it is unusual and rarely encountered bilaterally. In retrospect, incarceration followed by spontaneous reduction of Spigelian hernia probably accounted for the clinical picture in 1942, and also necessitated her admission in 1947. In each instance the patient's obesity and the failure of the physician to consider the diagnosis led to an inaccurate conclusion.

SUMMARY

A case of a 65-year-old obese female with bilateral Spigelian herniae is presented. A 180 degree clockwise volvulus of the sigmoid was found incarcerated in a left Spigelian hernia. On the day of discharge, an incarceration of the cecum in a right Spigelian hernia necessitated readmission. Both herniae were treated successfully by surgical intervention.

The authors gratefully acknowledge the assistance of LESTER L. VARGAS, M.D., *Surgeon-in-Chief* of the Rhode Island Hospital, in the preparation of this paper.

REFERENCES

[1]Anson, B. J., and McVay, C. B.: Anat. Rec., 77:213, 1940

[2]Zimmerman, L. M.; Anson, B. J.; Morgan, E. H., and McVay, C. B.: Ventral Hernia Due to Normal Banding of the Abdominal Muscles. Surg. Gyn. & Obst. 78:535, 1944

[3]Harless, M. S., and Hirsch, J. E.: Spigelian or Spontaneous Lateral Ventral Hernia. Amer. J. Surg. 100:515, 1960

[4]Read, R. C.: Observations in the Etiology of Spigelian Hernia. Ann. Surg. 152:1004, 1960

DO YOU KNOW?

- That health insurance benefit payments by insurance companies in 1962 are 11 per cent ahead of 1961.
- That in the first three months of 1962 insurance company health benefit payments totaled $947 million, compared to $854 million in the first three months of last year.
- That $374 million of the 1962 payments went to persons covered by hospital expense policies.
- That surgical expense insurance accounted for $117 million, regular medical insurance for $34 million, major medical insurance for $171 million, and loss-of-income insurance for $251 million.

COMMON LESIONS WITH NEUROSURGICAL IMPLICATIONS APPEARING IN THE NEWBORN

WALTER C. COTTER, M.D.

The Author. *Walter C. Cotter, M.D., of Providence, Rhode Island. Assistant Surgeon, Department of Neurosurgery, Rhode Island Hospital.*

COMMON LESIONS of neurosurgical interest in the newborn involve alterations in head size or shape, congenital defects of the spinal axis, and traumatic lesions to the extremities.

Synostosis

I. Cranial synostosis is a pathological condition of the bones of the skull resulting in distortion of the skull and the underlying brain. A suture line, instead of being a tough, fibrous bridge between two separate bony plates, is replaced by overgrowth of dense bone which firmly anchors the adjacent bony plates into a solid bony sheet. This restricts the mobility and alters the growth pattern of the involved bones producing distortion of the underlying developing brain and an increase in intracranial pressure. The two common types of cranial synostosis are sagittal synostosis and coronal synostosis. Sagittal synostosis is found predominantly in healthy male infants. It is a congenital defect fusing the two parietal bones into a single bone. Thereby, parietal expansion of the head is restricted. The pathological condition is readily apparent at birth. A palpable ridge along the area of the sagittal suture is pathognomonic. The head is long and narrow, especially posteriorly. The parietal bossae are absent. The brow is high and the frontal bossae are full. The baby's face is broader than the forehead. The anterior fontanel may or may not be open. This lesion is best treated in the first four to six weeks of life. An artificial suture is made to allow expansion of the skull in the biparietal diameter. This will allow a more normal skull contour and growth pattern and protect the underlying brain from increased intracranial pressure. It is an eminently satisfactory procedure. Though the best results are obtained by surgery performed in the early months of life, less satisfactory though still beneficial results are obtained by corrective surgery done later.

Coronal synostosis is a bony fusion replacing the coronal sutures so that the parietal bone on each side is anchored to the homolateral frontal bones by a hard, bony bridge instead of a pliable, connective tissue suture line. Thereby, elongation of the head is prevented. The diagnosis is readily apparent at birth. The head is flattened in the anteroposterior diameter and widened in the transverse diameter. The supraorbital ridges are flattened and the eyes tend to bulge. The nose is usually small and the chin tends to protrude. There may be associated congenital defects, especially of the ears, of the palate, of the nasal choanae, and of the heart. This is a hereditary disease found predominantly in females. Because of the associated anomalies, the prognosis for normal mentality and for normal growth and development is a bit more guarded than in the child with sagittal synostosis. These children, because of the marked deformity, should have surgery performed in the first two to three weeks of life for optimal results.

Various combinations of these defects are seen. Usually, when the combination exists, cranial and facial deformity is greater and consequently, surgery is advised at a very early age.

Meningocele

II. The meningocele problem is fairly straightforward. If the child has a true meningocele, that is, a sac along the midline of the back filled with cerebrospinal fluid, but not involving nerve struc-

continued on next page

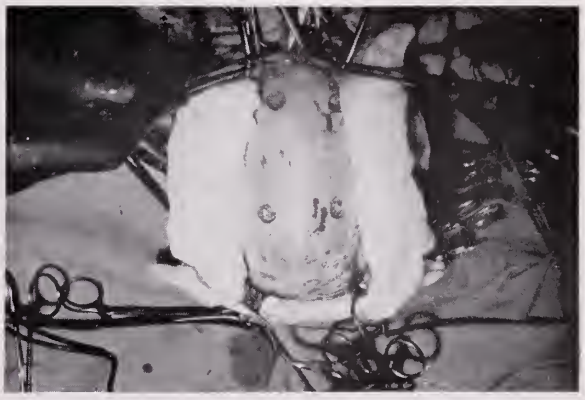


FIGURE 1. SAGITTAL SYNOSTOSIS

Photograph shows a ridge of bone replacing the normal suture line. At the upper end of the exposed calvarium, one can see a normal suture line going transversely. This is the lambdoid suture. Three burr holes have been placed on either side of the sagittal suture preparatory to removing this fused, bony suture line to create an artificial suture.



FIGURES 2 and 3

Appearance of the three and a half month old child with sagittal synostosis.



FIGURE 4

Facial appearance of newborn with left coronal and sagittal synostosis.

Notice that the overhanging right forehead has completely closed the right eye; whereas, the receding left forehead has pulled the left eye open. *Figure 4a.* Same as Figure 4, three years postoperative.

tures, this lesion should be removed, if possible. If there is no associated hydrocephalus and if the child appears to be in good condition, then surgery can be performed within the first day or two of life. This can be done under local anesthesia. At this time, the meconium is relatively sterile, and the baby is armed with antibodies transferred from his mother. This gives maximum protection against infection of the wound and lessens the danger of postoperative meningitis. If the base of the meningocele sac looks too large to close primarily, then surgery is deferred until the child is sufficiently grown, so that adequate undermining of the patient's skin can be carried out and the primary closure effected. Skin grafting to close a defect is contraindicated. If surgery is not carried out in the first few days of life, it is deferred until the frequent soft stools of the infant are replaced by the infrequent well-formed stool of the young child. If possible, it is best to remove the sac before it becomes an impediment to the child's walking and sitting.

Hydrocephalus, due to an associated Arnold-Chiari malformation, must always be watched for and promptly treated in these children, especially after excision of the meningocele. Arnold-Chiari Malformation is a congenital malformation of the medulla and cerebellum so that 1.) the cerebellar tonsils protrude from the posterior fossa through the foramen magnum into the upper cervical canal, producing obstruction to cerebrospinal fluid circulation through the foramen magnum, and 2.) the elongated medulla, protruding into the upper cer-

vical canal displaces the openings of the fourth ventricle downward into the upper cervical canal. The effect of this malformation on cerebrospinal fluid is as follows: Ventricular fluid normally issuing from the fourth ventricle to fill subarachnoid spaces of the brain and spinal cord, thence to be absorbed, is now delivered through the downward displaced openings of the fourth ventricle into the spinal subarachnoid pathways alone. Circulation upward through the foramen magnum to the cerebral and cerebellar subarachnoid spaces is thwarted in whole or in part by the downward displaced cerebellum which occludes the foramen magnum. Ventricular and spinal fluid pressure is thereby increased, producing hydrocephalus.

Meningomyeloceles are congenital defects in which a fluid-filled sac, usually thin-walled, protrudes from the midline structures of the back, usually in the lumbar area but occasionally in the thoracic and cervical areas. These lesions involve spinal cord and nerve roots. Consequently, there is an associated neurological defect ranging in severity from a hypotonic anal sphincter to spastic paraplegia. The decision regarding surgery depends on a meeting of the minds between the family of the patient and the doctors involved with the child.

Probably all children with meningomyloceles have an associated Arnold-Chiari malformation of the brain stem. Consequently, most of them will have an associated hydrocephalus. This topic will be continued under the general treatment of hydrocephalus.

If a baby with a meningomyelocele and a severe neurological deficit lives into early childhood, then the care of this crippled child will be greatly eased by excision of the huge sac. If this child has a compensated hydrocephalus and the sac is filled with spinal fluid, he will, in nearly all cases, when the sac is excised, become decompensated and acute hydrocephalus will occur. With large sacs in such situations, we elect to do a cerebrospinal fluid shunt procedure first, and then excise the meningomyelocele sac. This facilitates a good repair of the operative area and prevents further destruction of brain.

Encephaloceles are sac-like herniations of brain, with or without ventricular fluid. The lesions usually present in the midline or just off the midline. Those that are small usually consist only of a tuft of abnormal brain without ventricular fluid. Those presenting posteriorly are often difficult to differentiate from a cervical meningocele, or an intrauterine subgaleal hematoma. Those that present anteriorly are often thought to be nasal lesions. The correct diagnosis is often made when an intranasal biopsy is made, producing a cerebrospinal fluid fistula. These lesions are readily treated in the first few weeks of life.



FIGURE 5

Newborn with lumbar meningocele without hydrocephalus.



FIGURE 6

Same as Figure 5 ten days postop.



FIGURE 7

Lumbar myelomenigocele with hydrocephalus.

Note the bandage on scalp and the neck incision indicating recent ventriculo-auricular shunt for hydrocephalus.

continued on next page

Hydrocephalus

III. Hydrocephalus is due to an imbalance between the rate of cerebrospinal fluid production and the rate of cerebrospinal fluid absorption. In the newborn, this is usually caused by an atresia of the aqueduct of Sylvius. The head is usually large at birth and it steadily progresses in size at an accelerating rate. Corrective surgery is indicated whenever the child looks salvable. Thus, if he has lower cranial nerve palsies, such as a divergent squint, coupled with poor sucking reactions and hypotonia, and especially if there are associated cardiac murmurs, surgery is not indicated. The salvage of this child is a mistake. On the other hand, if the child appears to have a relatively normal facies, except for the downcast eyes of increased intracranial pressure, and if the child has a good sucking reflex and a good cry, he may be salvable. It must be noted that many children, except for their hydrocephalus, appear to be normal babies when first seen. However, as time goes on, and after the hydrocephalus has been corrected, it may be found that the child has severe brain damage. Then, one regrets that surgery for this hydrocephalic baby had ever been done. However, at the time surgery must be done, if it is to be done at all, it is difficult to separate all cases accurately into those of good potential and those definitely of poor potential. Consequently, if there is no contraindication as outlined above, early surgery is indicated. Once the diagnosis of progressive hydrocephalus has been established by appropriate studies, a cerebrospinal fluid shunting procedure is carried out. The size of the head and the rate at which it grows are the two factors which determine when surgery should be done. A mild degree of hydrocephalus, which has been arrested, is not incompatible with normal intelligence. The size of the baby is not a factor in judgment. We have successfully carried out shunts on tiny babies weighing as little as three and one-half pounds.

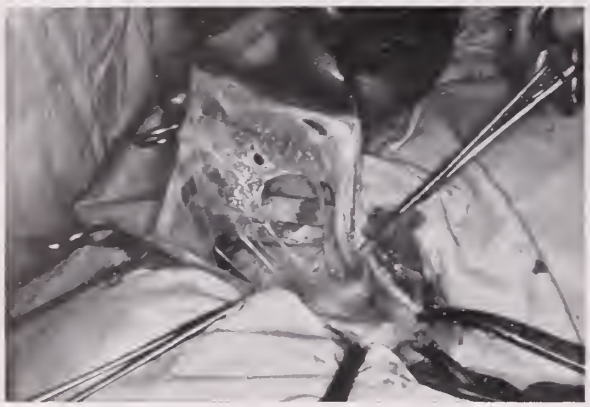


FIGURE 8

Same child as Figure 7 with sac excised and neural elements ending in sac wall demonstrated.



FIGURE 9

Same as Figure 7 and Figure 8 child, immediately postop.



FIGURE 10. HYDROCEPHALUS

These ventricles are 12 to 15 times normal size. Actual loss of brain substance is not as great as appears, because the head itself is considerably larger than normal.

Expanding Lesions

IV. Increasing head size is very rarely caused by subdural hematomas in the newborn. This lesion, so common a cause of increased head size in the older infant, very rarely occurs in the neonatal period and, consequently, forms a very minor role in the differential diagnosis of the large neonatal head. On the other hand, brain tumors responsible for increasing head size are not uncommon in this age group.

Although malignant gliomas rarely occur in the newborn period, the benign choroid plexus papilloma is perhaps the most common type of brain tumor noted in the newborn. These children appear as hydrocephalics but often have seizures in association with their increasing head size. The diagnostic procedures used for the hydrocephalic work-up will uncover these tumors, so that an erroneous diagnosis of hydrocephalus will not be made in the case of a brain tumor.

Birth Palsies

V. A weak upper extremity noted in the neonatal period is often due to injury to the nerves of



FIGURE 11

Ventriculo-auricular shunt for hydrocephalus which diverts cerebrospinal fluid through a catheter in the lateral ventricle into a subcutaneously-placed valve, then through this into a specially prepared catheter leading by the jugular vein to the heart.



FIGURE 12

Ventriculogram demonstrating choroid plexus tumor in three-week-old child with gross appearance of hydrocephalus.



FIGURE 13

Small upper extremity without neurological deficit and without vascular anomaly. Etiology is uncertain.

the upper arm persuant to a breech presentation. The lesion may be a direct trauma to the brachial plexus or avulsion of the cervical nerve roots. The differential diagnosis is not always easily established. Bloody spinal fluid in the presence of a homolateral Horner's syndrome is fairly convincing evidence for nerve root avulsion. Consequently, no recovery or very little recovery can be expected. If the injury is in the brachial plexus, then good recovery may be anticipated. On occasion, an unabsorbed hematoma involving the brachial plexus will have to be excised. Paraplegia, due to thoracic cord stretch injury occurring in the course of a difficult delivery of the after coming head, is occasionally seen. Recovery is not to be anticipated. Surgical exploration of the lesion has been unrewarding, but new techniques of anastomosing thoracic nerves above the lesion with the spinal cord below the lesion hold promise of some recovery.

It is important to remember that not every paralyzed arm or leg is due to injury occurring at birth. Maldevelopment of the brain, especially faulty or total lack of development of the motor cortex, will result in such paralysis.

We have attempted to outline the common neurosurgical lesions occurring in the neonatal period. The best surgical results are obtained by early surgery in the majority of those cases amenable to surgery.



FIGURE 14

Brain of child with spastic diplegia noted from birth. The sensori-motor strip is absent on each side. This child would appear clinically as a child with cerebral palsy due to brain injury. In fact, this is a congenital anomaly where the essential sensory and motor areas of the brain never developed.

CREDIT OMITTED

In the article published in the July, 1962, issue of the RHODE ISLAND MEDICAL JOURNAL titled *Acute Renal Failure Complicating Salicylate Intoxication: Role of the Artificial Kidney* the authors omitted inadvertently a credit to the John A. Hartford Foundation, Inc. whose grant makes possible the artificial kidney program at the Rhode Island Hospital.

JEJUNAL DIVERTICULITIS WITH PERFORATION AND PERITONITIS

A Case Report and Review of the Literature

LEONARD J. TRIEDMAN, M.D., AND ALBERT F. TETREAULT, M.D.

The Authors, *Leonard J. Triedman, M.D., of Providence, Rhode Island, Assistant Surgeon, Miriam Hospital, Providence.*

Albert F. Tetreault, M.D., of Providence, Rhode Island, Assistant Physician, Miriam Hospital, Providence.

JEJUNAL DIVERTICULOSIS is a well-described pathological entity, yet one which infrequently gives symptoms or presents as a clinical problem. The first case of jejunal diverticulosis was described by Ashley Cooper in 1884.[1] In 1881 Sir William Osler reported fifty-five diverticula in the jejunum of a patient at autopsy.[2] The reported incidence of jejunal diverticula varies with the degree of care with which they are sought. The incidence of jejunal diverticula in most autopsy series ranges between 0.2 and 0.5 per cent. In 1925 Spriggs and Marxer reported fourteen instances of jejunal diverticulosis in one thousand X-ray examinations.[3] In 1934 Rankin and Martin at the Mayo Clinic found only 3 in 956 small bowel X-ray studies.[4] When efforts were made to inflate the bowel with air at autopsy, the reported incidence was about 1.3 per cent.

Because of the relative infrequency of jejunal diverticulitis with perforation and abscess formation, the following illustrative case is reported in detail.

Case Report

This 86-year-old white male entered The Miriam Hospital with the chief complaint of pain in the left lower abdomen of three days duration. Three days prior to admission, the patient reported the gradual onset of steady left lower abdominal pain which was aggravated by trunk motion and associated with anorexia but no vomiting. A clinical diagnosis of diverticulitis in the sigmoid colon was made by his physician who prescribed 250 mg. of erythromycin four times daily. He voided insignificant amounts of urine during the two to three days prior to admission and was anuric for 24 hours prior to admission.

He had had a normal bowel movement just before the onset of his present illness but was subsequently obstipated. In 1954, cholecystectomy had been performed. Frequency, intermittency, and hesitancy of urination had been occasionally experienced over the preceding five years, and in 1958 benign prostatic hypertrophy was diagnosed. He had not observed pyuria, hematuria, or dysuria prior to this admission, but did suffer considerable nocturia. Early in 1961 diverticulosis of the sigmoid colon, scattered jejunal diverticula, and hiatal hernia were diagnosed roentgenologically. His hearing had been poor for years, and his memory had progressively deteriorated over the five year period prior to admission. He had occasionally complained to his physician of shortness of breath on minimal exertion and had been on 50 mg. of hydrodiuril daily. With this therapy ankle edema was kept at a minimum.

Physical examination on admission revealed a well-developed, thin, dehydrated, slightly agitated, confused, elderly white male in moderate acute abdominal distress. Temperature 101°F. (Rectal); pulse 96; respiration 24; blood pressure 130/64. The abdomen was mildly distended and diffusely tender, especially in the left lower quadrant, where local and rebound tenderness were demonstrated. Normal bowel sounds were present but hypoactive. Indirect inguinal herniae were present and easily reduceable bilaterally. His external genitalia and rectal examinations were unremarkable. Soft brown stool specimen in the ampulla was negative for occult blood. The prostate gland was 4-plus enlarged, firm, non-tender, rubbery and without masses. Immature cataracts were present, bilaterally. The chest was increased in A-P diameter and the lungs were clear to percussion and auscultation. Expiration was equal to inspiration. Cardiac dullness extended to the mid-clavicular line. The heart sounds were rapid, regular and without murmurs or extrasystoles. A_2 was equal to P_2.

The laboratory data on admission was as follows: White blood count 12,000 with a differential count of polymorphonuclear leukocytes 76; bands 4; juveniles 2; lymphocytes 18; hemoglobin 12.8

gms. per cent. The 75 ml. of hazy amber urine removed by catheter revealed: specific gravity 1.025; pH acid; albumin trace; sugar trace; acetone none; sediment negative. Blood urea nitrogen 86 mg. per cent; fasting blood sugar 156 mg. per cent; serum sodium 133 meq/l; serum potassium 4.8 meq/l; chlorides 100 meq/l; CO_2 28 meq/l. An electrocardiogram disclosed a sinus tachycardia interrupted by premature ventricular beats, a run of auricular flutter, and right bundle branch block.

Three days later laboratory data showed a white blood count of 17,500 with a differential count of polymorphonuclear leukocytes 61; bands 31; lymphocytes 8; hematocrit 42 per cent; blood urea nitrogen 32 mg. per cent; total protein 4.8 gm. per cent; albumin 2.7 gm. per cent; globulin 1.7 gm. per cent; serum amylase 68 mg. per cent (Somogyi); hemoglobin 11.1 gm. per cent, and serology negative. X-ray examination of the chest demonstrated segmental atelectasis of both lung bases, while repeated abdominal films suggested ileus of segments of the small and large bowels without mechanical obstruction. Electrocardiogram recorded slowing of the heart rate, digitalis effect and persistent right bundle branch block. On the sixth hospital day the white blood count was 31,000 with a differential count of polymorphonuclear leukocytes 83; bands 7; lymphocytes 10. Stool culture failed to reveal pathogens.

Nine days after admission the blood urea nitrogen was 38 mg. per cent; white blood count was 56,400 with a differential of polymorphonuclear leukocytes 88; bands 6; lymphocytes 6. The following day a large, black, loose stool was 4-plus positive for blood. Creatinine 3.05 mg. per cent; white blood count, 68,000 with a differential polymorphonuclear leukocytes 77; bands 16; juveniles 1; lymphocytes 6. Urine sediment contained clumps of pus cells, many fine granular casts, and occasional hyaline casts; specific gravity 1.005; albumin trace.

Course in the Hospital

At times the patient had lucid moments; but most of the time he was disoriented as to time, person, and place. Throughout his hospital stay his temperature ranged from 100°F. to 102°F. rectally. His blood pressure averaged 116/80 mm Hg. until his demise. Because of his age and debility, initial conservative management was elected; consisting of hydration, parenteral chloramphenicol, oral neomycin, digitalization, and eventually parenteral erythromycin. No localized abscess was noted on frequent and careful abdominal and rectal examinations. With hydration, urinary output increased to a maximum of 1030 ml. by the fourth hospital day and then gradually decreased to 130 ml. by the tenth hospital day. On the ninth hospital day, gastric distention was relieved by Levin tube suction and drainage. Over the subsequent 30-hour period 775 ml. of fetid brownish-green fluid was collected. From the tenth hospital day to his demise, the patient passed frequent loose, black stools. Renal shut-down was complete by the eleventh hospital day. He died on the thirteenth hospital day. An autopsy was performed.

Findings at Autopsy

1. Multiple diverticula of the jejunum with perforation of one to form multiple loculated peritoneal abscesses; fibrinous and fibrous peritoneal adhesions. Focal pancreatic necrosis, tail portion, with some interstitial pancreatitis.
2. Bronchopneumonia, pleural effusions and pulmonary emphysema.
3. Hypertensive and arteriosclerotic cardiovascular disease with mild left ventricular hypertrophy.
4. Multiple colonic diverticula.
5. Marked osteoporosis.
6. Arteriolonephrosclerosis.

concluded on next page



FIGURE 1
Post-mortem view of jejunum showing probe in perforation. Note other diverticula.

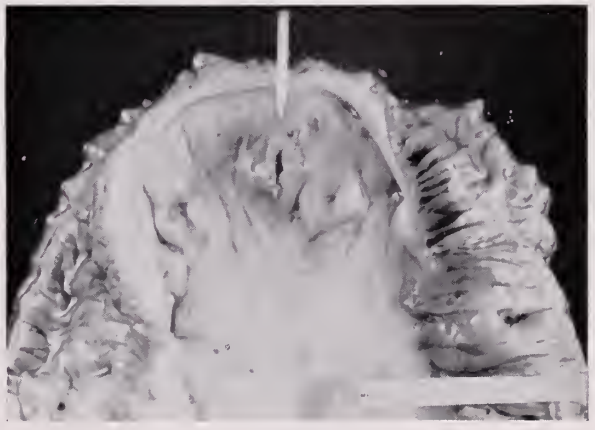


FIGURE 2
Perforation illustrated by pointer with jejunum open.

Discussion

Benson, Dixon and Waugh accumulated 300 cases of non-Meckelian jejunal diverticula, 122 of which were taken from their Mayo Clinic group. Jejunal diverticulitis seems to be a disease occurring primarily beyond the sixth decade of life. Symptoms are most prevalent in the seventh decade, and males predominate over females from 1.2:1 to 2:1 in incidence. The majority of these diverticula are on the mesenteric side of the bowel and dissect between the leaves of the mesentery. Their incidence decreases from the duodenojejunal flexure to the distal ileum. They are approximately seven times as frequent in the jejunum as in the ileum. They may be scattered or localized and range in size from 0.5 to 5 cm. in diameter. Typically they have a wide neck and are spherical in shape. The herniation of the mucosa and submucosa of the small bowel generally occurs through a weakness at the point of vessel or nerve penetration of the bowel wall. The extremely rare congenital diverticulum of the jejunum, in contrast, arises on the antimesenteric surface and is typically solitary. The herniation generally is thought to be produced by increased intraluminal pressure with relaxation of a segment of bowel between the two contracted segments, so-called "atypical spasm." Typically they are asymptomatic with, on occasion, vague symptoms of dyspepsia, primarily located in the left upper quadrant and paraumbilical area. They generally remain asymptomatic because of the fluid composition of the jejunal contents, the relatively lower intraluminal pressure in the small bowel as compared to the colon, the lower bacterial count of small bowel contents, and the unusually wide neck of the diverticula as compared to those of the colon.

Jejunal diverticula can be separated clinically into the following groups: no clinical symptoms; mild abdominal discomfort or gaseous dyspepsia; complications requiring surgery. In the Baskin and Mayo series of 87 patients with jejunal diverticula, nine presented with complications. Those which led to surgery were in their order of frequency: intestinal obstruction, often of a chronic nature; acute diverticulitis with or without generalized peritonitis; hemorrhage; traumatic rupture; volvulus. Jejunal diverticulitis with perforation is an unusual complication.

The most complete review of this problem was compiled by Thorek, who reviewed 14 cases from the literature and added one of his own. The symptoms varied widely, generally consisting of nausea, vomiting, abdominal tenderness and ileus. The patients presented usually with fever, tachycardia, and less constantly with a mass. The symptoms were typically in the left upper quadrant or left paraumbilical area. Occasionally the findings were primarily in the left lower quadrant, and on one occasion a mass was felt there. As Thorek pointed out, jejunal diverticulitis or perforation should be suspected in the presence of symptoms of an acute abdominal process suggesting perforation of a hollow viscus especially in the older patient presenting with pain and tenderness in the left upper quadrant and epigastrium. A history of antecedent trauma was obtained in two patients in whom a jejunal diverticulum had perforated. In this series of fifteen cases, thirteen were diagnosed surgically and two at the time of autopsy. Of those treated surgically, eleven were subjected to resection with primary anastomosis. In one, a purse string closure was done and in another a bypass procedure. The mortality rate of this group was 40 per cent.

In general, surgery is best reserved for the complications of jejunal diverticulitis. Asymptomatic jejunal diverticula found incidentally at laparotomy for unassociated disease are best left undisturbed. Choice of surgical procedure lies between resection with end-to-end anastamosis and by-pass. Resection of the entire segment of diverticulitis is preferable. If the involvement is very extensive, resection of only that portion of bowel involved in the complication is indicated. Management of perforation and abscess formation is dependent upon the nature of the local pathology encountered and the condition of the patient at the time of surgery.

SUMMARY

A case of jejunal diverticulitis with perforation and peritonitis is presented. Unfortunately the medical condition of the patient precluded definitive surgery and pathological diagnosis was obtained only on postmortem examination. In the pertinent literature reviewed, all agree that this diagnosis should be entertained in the elderly with atypical abdominal findings.

References

[1]Cooper, A.: Anatomy and Surgical Treatment of Abdominal Hernia. Philadelphia, Lea and Febiger, 1844

[2]Osler, W.: Notes on Intestinal Diverticula. Ann. Anat. & Surgery 4:202, 1881

[3]Spriggs, E. I., and Marxer, O. A.: Intestinal Diverticula. Quart. J of Med. 19:1, 1925

[4]Rankin, F. W., and Martin, W. J.: Diverticula of the Small Bowel. Ann. Surg. 100:1123, 1934

[5]Benson, R. C.; Dixon, C. F., and Waugh, J. M.: Non-Meckelian Diverticula of Jejunum and Ileum. Ann. Surg., 118:377, 1943

[6]Baskin, R. H., Jr., and Mayo, C. W.: Jejunal Diverticulosis: A Clinical Study of 87 Cases: Surg. Clin. No. America 32:1185, 1952

[7]Thorek, M., and Manzanilla, M. A., Jr.: Perforated Jejunal Diverticula. Jour. of the Intern. Coll. of Surg., 21:409, 1954

Editorials

TUBERCULIN TESTING PROGRAMS

According to a compendium compiled by the American School Health Association, a national organization of educators and health workers serving children and youth in the nation's schools, only nine states in the country provide their schoolchildren with tuberculosis screening programs which fully meet the Association's standards. Rhode Island is not listed among these nine qualifying states. In fact the state nearest to New England in this group is Illinois, with the remaining eight even farther west and south.

The suggested program of the Association includes a regular screening by means of the tuberculin test of all children in school through grade twelve and adult school personnel. Those reacting to the test are given immediate chest X-ray examination and treatment if required. A search is made promptly among associates and family contacts of reactors to find others who may have tuberculosis.

The Rhode Island section of the compendium indicates that regulations governing tuberculosis screening of schoolchildren in this state are governed by the local community School Health Committees.

Mass tuberculin testing programs have advantages and disadvantages. Some school systems have fostered tuberculin testing programs among the students for many years without adequate follow-up of either reactors or associates. Some have examined the reactors, but have made no attempt to examine the associates of the reactors. Some have adequately examined both reactors and associates, but with such variation in results obtained that confusion has resulted in the minds of many health officials. Cost analyses of this type of program are rare.

As long ago as 1905 the Providence Tuberculosis League had been active in Rhode Island in fighting the number one infectious disease killer, tuberculosis. This voluntary health agency provides free X-ray services and tuberculin skin testing for both children and adults upon referral by their physicians. Last year the League examined 35,218 patients, approximately 55 per cent of whom were Providence residents and the remainder from other sections of the state.

While we do not suggest that Rhode Island arbitrarily comply with the program put forth by the American School Health Association, we do feel that valuable information may be made available to all our physicians through the state and local health organizations. In this way individual decisions will be left to the judgment of the family physician, while a vital association will be maintained through utilization of the services of our local and state health organizations.

The results of such an integration of the efforts of all interested parties might well place Rhode Island in the forefront in this aspect of preventive medicine.

SOME DOUBTS ABOUT THE "SILENT SPRING"

Few living scientists can write with the grace, style, and clarity of Rachel Carson. She established her place in current literature with The Sea Around Us, published a few years back. She has again undoubtedly scored a success with Silent Spring, originally serialized in The New Yorker magazine, and more recently published in book form (Houghton Mifflin Company). Her eloquent portrayal of an imaginary town blighted beyond recovery by man's spraying for an insect pest is indeed chilling prose. The scope of her research for this work is impressive. Sensitized by her persuasiveness, we have taken note of news items that would otherwise probably have evoked no more than a casual glance from us. In The New York Times of August 5, 1962, there appeared a report datelined Miami, headed *Spraying of Flies Irking Floridians.* "Residents of South Florida," it said, "have been protesting angrily over the spraying of insecticide from airplanes ever since the campaign to eradicate the Mediterranean fruit fly began here last June. Undoubtedly the most unpopular individuals in South Florida today are the pilots of the spraying planes at whom housewives figuratively

continued on next page

shake their brooms and whom automobile owners accuse of every mark on their vehicles."

On September 16th THE TIMES carried a story from Bloomfield Hills, Michigan, about a seven-cubic-foot freezer at the Cranbrook Institute filled to the top with dead birds awaiting chemical analysis, among them many robins, brought in by residents who found them dead or dying with symptoms associated with DDT poisoning. In past years the bodies of many such birds had been shown, on analysis, to have carried toxic amounts of DDT. Robins, it was feared, would be annihilated. The spraying was for Dutch elm disease, which some plant pathologists, notably those in Rhode Island, believe should be eradicated by other means.

These two reports give immediacy and lend a certain credence to Miss Carson's thesis. In three areas, however, we feel that she has somewhat exceeded her capabilities. In the first instance she challenges the effectiveness of the Food and Drug administration's inspection for adulteration with pesticides. While her plea for more effective regulations and greater numbers of inspections are not really controversial, her implication that her judgment of permissible tolerance levels and present effectiveness of inspection is better than that of experts in the field is gratuitous and productive of unwarranted fears on the part of the public.

In the second instance, there is her rather oblique implication that "Many cases, victims of leukemia, of a severe depression of the bone marrow called aplastic anemia, of Hodgkin's disease, and of other disorders of the blood and blood-forming tissues" could be due to DDT, chlordane and other chemicals, because they "have had a history of exposure" thereto, is hardly within the sphere of her special talents.

Finally, in the area of pesticides for disease prevention, Miss Carson again uses a scare technique. The great world-wide success in the control of typhus, particularly during World War II, and of the impending eradication of malaria, the world's greatest killer, make one wonder about her campaign of disparagement. In the PROVIDENCE EVENING BULLETIN for August 22, 1962, B. R. Bhandari, chief administrative officer of Hindustan Insecticides, Ltd., is quoted as saying that the end of the malaria threat in this country should come in about two years. This, he predicted, would enable India to turn its DDT production over to the agricultural field. Yet, Miss Carson dismisses the whole program with the statement, "Some malaria mosquitoes that have been sprayed in huts have a habit that reduces their exposure to DDT so drastically as to make them virtually immune. Irritated by the spray they leave the huts, and outside they survive." This is a rather cavalier dismissal on limited grounds of a program of proven value. Resistance is a phenomenon well known to physicians, but it has certainly not led to an attitude of futility.

Rachel Carson is a biologist of considerable stature. She has been a member of the zoological staff of the Marine Biological Laboratory at Woods Hole, has been employed by the Federal Bureau of Fisheries, and was for three years editor-in-chief of FISH AND WILDLIFE SCIENCE magazine. Besides her Master's degree from Johns Hopkins, she holds no less than four honorary doctorates, one in science and three in letters. Her qualifications as a biologist, and more specifically as an ecologist, and her skill as a writer are unquestioned. But there is some serious doubt whether she is well advised to exert her no mean talents to sow feelings of terror in the medical field, where her qualifications are somewhat more in doubt.

HOW TO PROPERLY SPLIT INFINITIVES

IN A RECENT ISSUE of a national specialty journal our editorial attention was caught by the following phrase: "To completely eradicate carcinoma of the gall-bladder, cholecystectomy should be accompanied by etc., etc." Since we were first introduced to English grammar as an eager, if somewhat callow, teen-ager, we have had it impressed upon our mind that splitting infinitives is one of the cardinal sins of literary composition. This rule of good writing has been so generally ignored of late, that we took the trouble of inquiring of an English professor in one of our better local colleges, whether this ground rule of good grammar has been allowed to lapse. Our reason for asking this question was a rather unexpected finding that United States Presidents who have been graduated from West Point *do not* split infinitives, while on the other hand, certain other Presidents who have *more* recently been graduated from Harvard, *do*. In reply to our question, the said professor, who is strictly a traditionalist, replied: "I do not permit *my* students to split infinitives."

Having therefore satisfied ourself that the quotation in the opening sentence is improper, we attempted to rearrange it, to see how *we* would have written it. First we tried "completely to eradicate." Somehow this seemed to be slightly more awkward than the original. Then we tried "To eradicate completely." This seemed a little better, but perhaps redundant. Redundant? Ah! yes. Perhaps there is something more wrong than first meets the eye. We then looked up "eradicate" in

Webster's New Collegiate Dictionary and found this definition: "To pluck up by the roots; hence, to extirpate. Syn. See exterminate." We then tried exterminate: "To destroy utterly; to annihilate; to get rid of completely (*sic*)." We concluded our research by seeking the meaning of redundant: "Exceeding what is natural, usual, or necessary; superfluous as, *redundant* words in a statement;" and for redundancy: "Quality, instance, or state of being redundant, superfluity; excess, specif, use of more words than needed to convey the thought. Cf. Pleonasm. Tautology."

Having thus confirmed our judgment that the initial quotation was indeed an example of pleonastic tautology, to be redundant, we thought we would again recast the phrase. We tried: "To eradicate carcinoma of the gall-bladder. . . ." Now we could breath more freely. Splitting the infinitive was not the monster, but redundancy.

Reflecting a little further we wondered: "Is not tautology, rather than the split infinitive, one of the greater faults of current medical literature?"

HAPPY NEW YEAR!

Here they come again! The new model automobiles!

The various media of advertising proclaim their style, their size, their speed, and their power. Yet in spite of all the innovations they are still the same old instruments of destruction — driven by the same old-fashioned driver — man, who last year left the alleys, streets and turnpikes of the nation littered with more than three million, ninety-four-thousand casualties — mothers and fathers, sisters and brothers, large and small, old and young. The automobile New Year arrives so smartly, and it ends so wretchedly!

This, then, is the time for all of us to renew our resolutions to drive with care, to drive only when in good health and when sober, and to obey the laws of our communities as well as the Golden Rule.

This is the time for us to install seat belts, and to use them.

This is the time for us to insist that our children walk more, and travel by bus. This is the time for the automobile manufacturers to spend more on safety campaigns, to install better door locks, better visibility aids, more instrument padding, and to spend less on horsepower.

This is the time for us as physicians to demand that the ill, the emotionally disturbed, and the aged, do not drive automobiles, and it is always the time to report such disabilities of potential drivers to the Motor Vehicle Department.

If all of us do not act, then the casualties will continue to rise. The 3,094,000 casualties incurred last year signify an incredible amount of miserable, crippling, painful, bloody suffering and death. There is no reason to expect at the present time that this number of casualties will not rise to a higher total in the future.

Only part of the blame falls on the machine. It is the drivers — the people — who are chiefly at fault. And all of us are the drivers.

THE A.M.A. STUDENT LOAN FUND

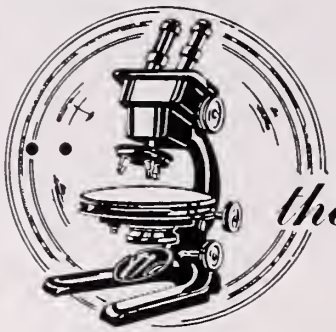
A far-reaching new medical education loan guarantee program is now under way in American medicine. The goal of this program is to help eliminate the financial barrier to medicine for all who are qualified and accepted by approved training institutions. It is designed to provide a means of financing a substantial portion of the costs of a medical education.

The loan program for medical students, interns and residents is the result of a co-operative effort by American medicine and private enterprise.

The program is administered by the American Medical Association's Education and Research Foundation. The ERF has established a loan guarantee fund. On the basis of this fund, the bank will lend up to $1,500 each year to students. The ERF in effect acts as co-signer. For each $1 on deposit in the ERF's loan guarantee fund, the bank will lend $12.50.

More than 3,300 students, interns and residents have borrowed more than $6,000,000 through this fund since it was started last February. Physicians and others have contributed almost $700,000 to the loan guarantee fund, which makes possible these loans.

The guarantee fund is almost depleted and more money is needed immediately to keep up the loan program. Eventually it will become self-sustaining as loans are repaid, but right now substantial financial help is needed. Your check to the AMA-ERF, 535 North Dearborn Street, Chicago, will help to keep this important program viable. Contributions to the Foundation are tax deductible.

THROUGH . . .  *the Microscope*

National Bilirubin Survey Announced

In order to stimulate interest in the accuracy of bilirubin determinations the College of American Pathologists Standards Committee announces a National Bilirubin Survey, available to all physicians and hospitals.

Accurate bilirubin measurements are of great importance in decisions as to the need for exchange transfusion in newborn erythroblastosis fetalis. They are of great importance in the differential diagnosis of the various icteric syndromes in patients of all ages. They are important in evaluating prospective blood donors. In all of these cases, a poorly calibrated technique will lead to serious mistakes in the care of the patient.

Bilirubin measurements must be consistent from year to year so that treatment is based upon the same criteria in successive patients. Therefore, reliable bilirubin standards should be utilized with stable photoelectric photometers.

Participants will first receive a set of survey samples. Following the survey, a critique of bilirubin standards and methods of analyses will be provided. Questions arising during the survey may be directed to the Committee.

Those who wish to participate in this bilirubin survey may do so by sending $8.00 to the Standards Committee, College of American Pathologists, Prudential Plaza, Chicago 1, Illinois. Applications must be received not later than August 1, 1962.

One Million Workers Out Each June Day

Although June is the healthiest month of the year when it comes to persons being absent from work due to illness, on an average day this month about one million workers will be at home sick, the Health Insurance Institute predicted.

On an average day last June, 1.56 per cent of the working civilian population, or 1,076,000 persons, were sick and not on the job. Of this number, 807,000 were absent a work week or more, and 269,000 were absent less than a week. The Institute said this was the lowest monthly figure for 1961.

In six of the last seven years June has had the lowest monthly figure in percentage of working civilians absent from their jobs a week or more because of illness, according to data from the U.S. Department of Labor. Only in 1958, when June's percentage was 1.16 to 1.13 for August, was June not lowest in the years from 1955 through 1961.

February Highest

On the other end of the scale, February usually has the most workers out because of illness. On an average day in February, 1961, 2.14 per cent of civilian workers, or 1,385,000 persons, were out sick, and 997,000 of them for a week or more. This February the percentage was 2.65 when 1,742,000 workers were out.

The Institute pointed out that much of the financial loss caused by this absence from work is absorbed through insuring mechanisms. More than 43 million workers are assured that they will continue to have an income when they are disabled by off-the-job illness or injury, declared the Institute.

Some 33 million of these workers are protected by loss-of-income policies issued by insurance companies and the remaining 10 million are covered by other formal arrangements. In 1961, insurance companies alone paid out some $855 million in benefits to persons protected by loss of income policies.

Hospital Association Report on Intern Deferment

Recent discussions with the National Advisory Committee on the Selection of Physicians, Dentists and Allied Specialists have clarified several issues arising from the recently accelerated program of drafting interns and residents into military service. There is no basic change or new administrative regulation concerning the method of drafting physicians. Selective Service officials, although aware of the educational value of hospital residency programs, are finding it necessary to use the draft mechanism to bring into the armed services the number of physicians now needed.

Defense Department as well as Selective Service officials advise that if each draft-age doctor keeps his local Selective Service board informed of his residency status, and if each hospital administrator keeps fully informed of the military classification

of his house officers, the draft problem can be greatly alleviated. Selective Service officials plan to publish specific bulletins to provide doctors and hospitals with all necessary current information about the accelerated draft.

Meanwhile, there are a number of steps which both residency candidates and hospitals could and should take to avoid unnecessary disruption of training programs:

1. Prospective residents will be automatically classified 1-A upon completion of internship. It is essential that the prospective resident notify the proper Area Board about his appointment. The proper Area Board is that which has jurisdiction over the locale of the hospital to which he is appointed. Selective Service officials emphasize that such notification of the Area Board in no way will reflect on the resident's status with his own local board. If the prospective resident waits until he receives a 1-A classification notice from his local board, he has only ten days in which to make an appeal. Failure to appeal within the ten-day period will nullify his right to appeal.
2. Hospitals should ask all candidates for residency positions to furnish their Selective Service numbers, their draft classifications, and the addresses of their local boards. Selective Service officials recommend that the hospital notify the respective local boards of the effective dates of each resident's appointment. This notification is not an appeal, but it informs local boards of facts which may help in making a judgment on a draft candidate's change of status. An appeal from a draft status should be directed to the Area Board. The appointing hospital may, of course, support the prospective resident's appeal by letters to the Area Board.
3. Because the present national emergency is likely to be of extended duration, Selective Service officials urge hospitals to consider carefully the draft status of each prospective resident. It is recommended that, to the extent feasible, a hospital appoint draft-exempt candidates in sufficient proportion so that continuity of its residency program may be maintained.

Seven out of Ten Retirees Can Retain Health Insurance

Seven out of every ten employees covered under group health insurance policies issued by insurance companies during 1961 have the right to retain their protection when they retire, the Health Insurance Institute reports.

The Institute said its findings showed that there was a continuing trend in group health insurance policies toward coverages which employees can carry into their retirement years.

continued on next page



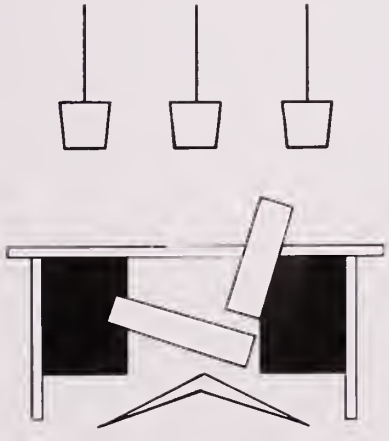
Health Havens
100 WAMPANOAG TRAIL
EAST PROVIDENCE, R. I.
438-4275

A Truly Modern, Intermediate Care Facility Providing the Ultimate in Nursing Home Care at Reasonable Rates

Prepared to accept and adequately care for many acute cases as well as the more general convalescent and nursing home patients. We are limited to adults.

Our Nursing Administrator, Mary E. Baxter, R.N., will be pleased to discuss patient care with you.

Attractive & Functional Offices
by BENÉ & CO., INC.



Designers & Suppliers of Offices
150 Dorrance Street • Providence 3, R. I. • GAspee 1-5228

The Institute report was based on its second annual analysis of data supplied by insurance companies which were responsible for 74 per cent of the total group health insurance premiums in the United States in 1960. The data sampling consisted of some 2,300 new group coverages issued last year protecting 295,474 employees, declared the Institute.

The retention of the worker's health insurance coverage after retirement is achieved in two ways: by converting his group benefits to an individual policy upon retiring or by continuing the benefits on a group basis.

Rhode Island a Leader in Rehabilitation

A recent report from the secretary of Health, Education and Welfare shows that during the fiscal year that ended last June 30 Rhode Island ranked seventh among the states in the number of rehabilitations per 100,000 of population, with a total of 107 rehabilitants. Pennsylvania led all the states with a total of 9,311.

For the first time in the forty-two-year history of the program the national total of rehabilitations which restored people to productive and satisfying life topped the one hundred thousand mark with a total of 102,378.

Nursing Home Accreditation Grant Announced

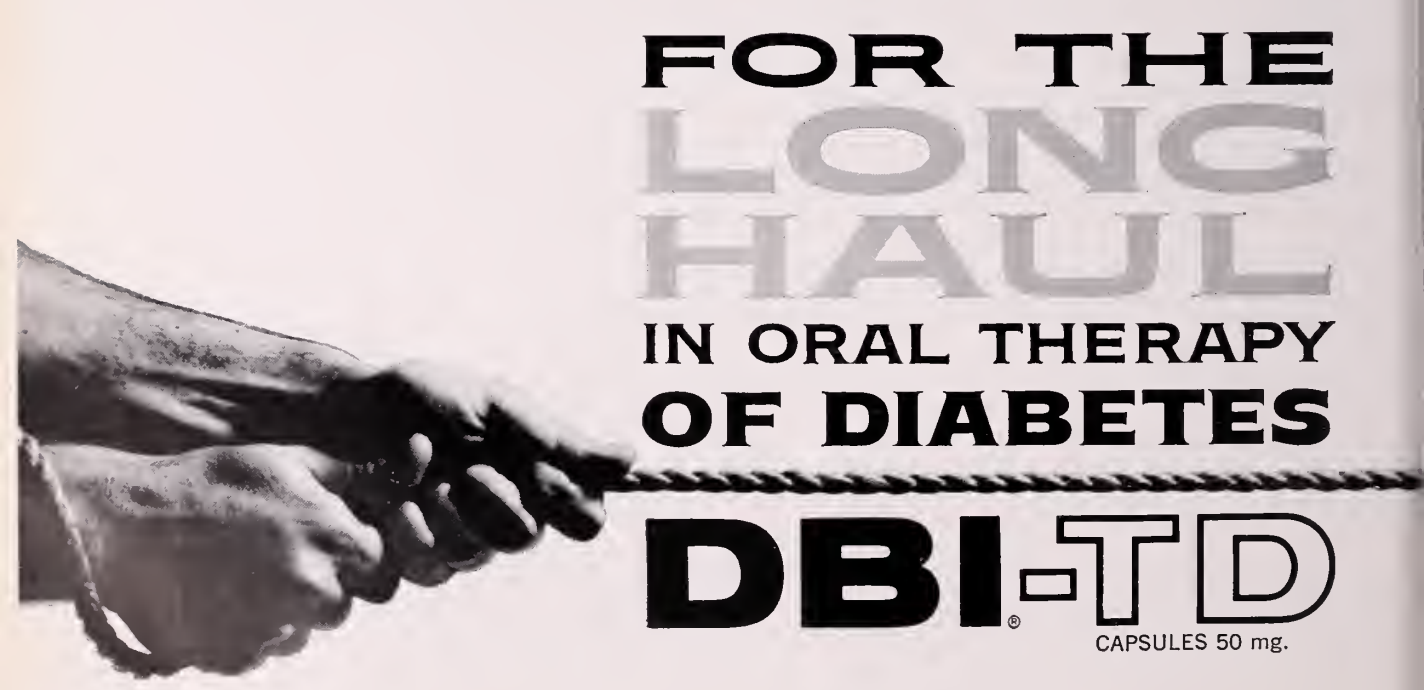
A grant from the John A. Hartford Foundation of $49,500 to develop a program of accreditation for nursing homes and inpatient care institutions other than hospitals was announced recently by the Hospital Research and Educational Trust of Chicago. The work will be carried out by the Joint Commission on Accreditation of Hospitals.

Coverage Tops 67% in 31 States

Thirty-one states have more than two thirds of their population protected by some form of voluntary health insurance, the Health Insurance Institute reported recently.

As of the end of 1961 New York State, with a coverage figure of 90.7 per cent based on more than 15.5 million insured residents, led all 50 states, followed by Rhode Island (87.8), Pennsylvania (87.7), Ohio (85.0), Connecticut (84.0), and Illinois (82.9), the Institute declared.

The Institute said other states with more than two thirds of population covered by health insurance are California, Colorado, Delaware, Indiana, Iowa, Kansas, Maine, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, New Hampshire, New Jersey, North Carolina, North Dakota, Oklahoma, Oregon, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming.



In addition, the coverage figures for 16 states fell between half and two thirds of population. Only 3 states — Alaska, New Mexico, and Mississippi — had less than 50 per cent coverage, with Alaska the lowest at 37.1 per cent.

On a regional basis, the nine Northeast states of New York, New Jersey, Pennsylvania, Connecticut, Massachusetts, Rhode Island, Vermont, New Hampshire, and Maine boasted the greatest percentage of population with health insurance, 84.6 per cent based on 38.5 million insured persons in the region's 45.5 million population.

Welfare Prescription Program Praised

Total payments to the 12 states now taking part in the Merck Sharp & Dohme Welfare Prescription Program have amounted to about $300,000 since the program was started in early 1961. This was reported recently by William B. Van Buren, assistant to the general manager of Merck Sharp & Dohme, before a Conference of State Welfare Finance Officers at the Sheraton-Palace Hotel here.

Under the program, Merck Sharp & Dohme pays monthly to each state 10 per cent of the amount the state pays to retail pharmacies for prescriptions written for and filled with MSD products under the state's welfare program.

Reactions to the plan have been enthusiastic among welfare directors of the participating states, Mr. Van Buren said. He cited comments of Doctor P. Joseph Pesare, medical director of the Rhode Island Division of Public Assistance, who wrote MSD recently that companies offering such reimbursement programs have provided "a substantial contribution to the medical care of the needy and, at the same time, fortified our justification for continuing to recognize payment for accepted brand-name drugs rather than generic prescriptions."

Participating states now include California, Connecticut, Florida, Illinois, Indiana, New Hampshire, New Mexico, Oregon, Pennsylvania, Rhode Island, Utah, and Wisconsin.

Chest Physicians Statement on Cigarette Smoking

The Committee on Cancer of the American College of Chest Physicians for a number of years has been studying the effect of cigarette smoking on the pulmonary and cardiovascular systems. The members of the Board of Regents of the College are convinced that sufficient evidence has been accumulated to warrant issuing an official statement with regard to cigarette smoking and health. Accordingly, a resolution connecting cigarette smoking with various pulmonary and cardiovascular conditions was approved by the Board and issued by the College.

concluded on next page

DBI-TD
brand of sustained action phenformin HCl

first and only
timed-disintegration
oral hypoglycemic
dosage form

long term response . . . "Secondary failure is unlikely to occur" with phenformin[4] (DBI-TD capsules, DBI tablets). Phenformin has been successfully administered daily in diabetics in one study for over 3 years[2] and in another for up to 4½ years[1] with "a virtual absence of acquired resistance or true secondary failure."[1] Indeed, DBI has produced a satisfactory response in 55 to 60% of tolbutamide secondary failures.[3,7]

long term clinical safety . . . No liver or parenchymal organ toxicity has been observed after up to 2½ years of daily use of DBI-TD — nearly 5 years with the DBI tablets.[1,2,9] "The absence of hypoglycemic reactions" with phenformin "has been conspicuous."[5]

long term tolerance . . . DBI-TD is well tolerated with minimal g.i. side effects.[2,6,8] Radding et al.[6] report, "the relative freedom from gastrointestinal side effects was particularly reassuring . . . and in no instance was it necessary to discontinue the drug."

long term convenience . . . Once a day dosage — or at most twice a day — for great majority of diabetics makes DBI-TD simple and convenient therapy. Each dose lowers blood sugar gradually, smoothly, for about 12 to 14 hours.[6]

DBI-TD (brand of Phenformin HCl — N¹-β-phenethylbiguanide HCl) available as 50 mg. timed-disintegration capsules; bottles of 100 and 1000 capsules. Also available as DBI tablets, 25 mg., bottles of 100 and 1000.

Important: Before prescribing DBI-TD, the physician should be thoroughly familiar with directions for use, including indications, dosage, possible side effects, precautions and contraindications. Write for complete literature.

1. Pomeranze, J.: Clinical Med. 8:1155, June 1961. 2. Krall, L. P. and Bradley, R. F.: Geriatrics 17:337, May 1962. 3. DeLawter, D. E. et al.: J.A.M.A. 171:1786, Nov. 28, 1959. 4. Perkin, F. S.: J.A.M.A. 173:36, May 7, 1960. 5. Pearlman, W.: Phenformin Symposium, Houston, Feb. 1959. 6. Radding, R. S. et al.: Metabolism 11:404, April 1962. 7. Gold, A. et al.: Applied Therapeutics 2:137, 1960. 8. Brown, G. D. and Gabert, H.: Applied Therapeutics 4:451, May 1962. 9. Gold, A.: Applied Therapeutics 4:466, May 1962.

u. s. vitamin & pharmaceutical corp.
Arlington-Funk Laboratories, division • 800 Second Avenue, New York 17, N. Y.

The resolution stated that the weight of scientific evidence distinctly indicates that cigarette smoking and the inhalation of other atmospheric pollutants have an association relationship which strongly suggests a causal connection with chronic bronchitis, pulmonary emphysema, cor pulmonale, cardiovascular diseases and cancer of the lung.

The College in its official statement urged its members and the medical profession in general to intensify their educational campaign directed toward the public, and the youth in particular, relative to the hazards of smoking.

The College urges that efforts to control atmospheric pollution be encouraged and that support be given to endeavors in the field of research for additional scientific information concerning other etiologic agents.

The resolution was introduced by Doctor J. Winthrop Peabody, Jr., Washington, D.C., to the House of Delegates of the American Medical Association and was referred to their Council on Drugs which is conducting a study on the relationship between tobacco and disease. A preliminary report is to be presented by the Council within 12 to 18 months. Surgeon General Luther L. Terry of the U.S. Public Health Service has announced plans for an advisory committee to make recommendations on the health aspects of smoking. The College resolution will be referred to this committee.

The Nineteenth Annual

NEW ENGLAND

POSTGRADUATE ASSEMBLY

November 6, 7, and 8, 1962

Statler Hotel . . . Boston

Open to Every Doctor of

Medicine in New England

Health Insurance Progress: 1941-61

In the space of 20 years, the number of people protected by health insurance has gone from one out of every eight in the United States to the present figure of three out of every four persons, the Health Insurance Institute has reported.

In 1941, 12 per cent of the U.S. civilian population were protected by some form of health insurance, the Institute said, while at the beginning of this year 74 per cent of Americans were so covered. At the midway point, 1951, some 56 per cent of the population had health insurance.

Twenty years ago, only 16 million Americans were covered by hospital expense insurance. Since then there has been an 8-fold increase and over 135 million persons were protected against the costs of hospital care at year-end 1961, declared the Institute. In 1951, over 85 million were insured.

The Institute said this explosive growth can be attributed to many factors, among which is the public's growing awareness of the value of modern health care and its need to find a mechanism to help prepay the costs of such care. The same type of growth has been shown, said the Institute, by other forms of health insurance.

Surgical Insurance

In 1941, nearly 7 million Americans had surgical expense insurance, but in the following 20 years there was an 18-fold increase and at the end of 1961 over 125 million persons had protection against the cost of surgical bills, the Institute said. In 1951, nearly 65 million persons had surgical insurance.

Regular medical expense insurance covered a little more than 3 million Americans in 1941. However, there was a 31-fold increase in coverage in 20 years so that more than 92.5 million persons were covered last year. In 1951, close to 28 million persons were so protected.

MON., NOV. 5 . . . Scientific Meeting. Providence Medical Association. At the Medical Library, 8:30 P.M.

Curran & Burton, Inc.

INDUSTRIAL
AND WHOLESALE

COAL **OIL**

17 CUSTOM HOUSE STREET
PROVIDENCE, R. I.
DExter 1-3315

When you choose an anorectic—

"Does it help the patient maintain the proper diet, is it free of dangerous side effects, and does the patient like it?"[1]

Perhaps you'll find, as Stevenson did, "['Eskatrol'] seems to meet these criteria better than most."

1. Stevenson, L.E.: M. Ann. District of Columbia *30*:409 (July) 1961.



ESKATROL®
SPANSULE®
brand of sustained release capsules

PRESCRIBING INFORMATION

Formula: Each 'Eskatrol' *Spansule* sustained release capsule contains Dexedrine® (brand of dextro amphetamine sulfate), 15 mg., and Compazine® (brand of prochlorperazine), 7.5 mg., as the dimaleate.

Recommended Dosage: One 'Eskatrol' *Spansule* capsule daily, taken in the morning.

Side Effects: Side effects (chiefly nervousness and insomnia) are infrequent, and usually mild and transitory.

Cautions: Clinical experience has demonstrated that 'Eskatrol' (containing the phenothiazine derivative, prochlorperazine) has a wide margin of safety and that there is little likelihood of blood or liver toxicity or neuromuscular reactions (extrapyramidal symptoms). The physician should be aware, however, of their possible occurrence.

'Eskatrol' *Spansule* capsules should be used with caution in the presence of severe hypertension, advanced cardiovascular disease, or extreme excitability.

Prescribing information adopted Jan. 1961

Smith Kline & French Laboratories SK&F

BOOK REVIEWS

A STUDY OF PSYCHOPHYSICAL METHODS FOR RELIEF OF CHILDBIRTH PAIN by C. Lee Buxton, M.D. Co., Phil., W. B. Saunders 1962. $4.75

This excellent little book (only 102 pages) presents a rather complete coverage of the various methods of mental and physical training for the relief of pain in childbirth as observed by the author in various clinics here and abroad. The first two chapters discuss the problem of pain and more specifically, the causes of pain in labor. The remaining pages are devoted to a description and study of each of the non-pharmacological methods of relief, including the Pavlovian Conditioned Reflex, Grantly Read, Autogene, and hypnotic methods. A chapter on the value of the husband's presence in the labor and delivery room is excellent.

The bibliography is extensive and complete, although many of the foreign journals will not be readily available.

Josiah Sacks, M.D.

FINANCING MEDICAL CARE. An Appraisal of Foreign Programs. Edited by Helmut Schoeck. The Caxton Printers, Ltd., Caldwell, Idaho, 1962. $5.50.

Helmut Schoeck is an associate professor of sociology at Emory University. Born in Austria, he studied at the universities at Munich and Tübingen in West Germany. After four years of concurrent training in medicine and experimental psychology in Munich, he completed his studies with a Ph.D. in sociology and psychology at Tübingen. Doctor Schoeck came to America following World War II. During 1953 and 1954, he was a visiting Research Fellow in Sociology at Yale where he continued studies in medical sociology. He had published articles on the organization of medical care as early as 1946.

Doctor Schoeck's book concerns itself with three main questions: 1. Is it true that foreign systems are working with a high degree of success?; 2. What have been the unexpected effects of the compulsory insurance principles in health insurance and national health schemes? and 3. If countries had it to do all over again and were still as free as the United States is to embrace or reject such a program, would they again adopt these systems currently praised as models of progress?

Fifteen experts abroad were invited to report on medical systems as they exist today in Britain, France, Germany, Austria, Sweden, Switzerland, and Australia.

This was the first book to provide an inside scrutiny of various systems of compulsory health insurance. These selections, written by authorities from seven countries, are representative of the different types of "state medicine" currently in effect. Economists, actuaries, political analysts, physicians, medical researchers, statesmen, and a theologian — all thoroughly familiar with the inner workings of their own nations' medical systems — have contributed to this unique book.

Financing Medical Care is "must" reading for anyone who asks if the United States is inexcusably lagging behind in social progress and the "march of history" by not having compulsory and comprehensive health insurance under government auspices. It should also be read by those who prescribe government control as the cure for present medical care inadequacies.

Doctor F. A. Hayek of the University of Chicago, in his preface states: "The creation of any kind of government controlled compulsory organization of medical service is a step which may have the most far reaching effects on the structure of a society and even on the character of the people. It raises complex and serious problems on which much concrete experience has been accumulated during the past eighty years. There are perhaps few other fields in which so many admitted mistakes have been made since the last of the nineteenth century and where it is at the same time so difficult to correct the consequences of a misguided earlier policy."

The American people face important decisions in this field at a time when it is still difficult to obtain information on which to base any decision. This is true not only for the layman, but also for those whose profession it is to study society. The latter group find it far from easy to construct an adequate picture of the results of experiments with state medicine in other countries.

Social scientists with no particular desire to import government sponsored health plans into the

United States have had little occasion to study it. As a result, what information is readily available to the American reader presents almost exclusively the interventionist or statist point of view. Most of the writing on this subject is the work of enthusiasts for a cause, of writers who want to persuade the American public of the desirability of a particular kind of medical care scheme.

When we review the popular writings on government plans for financing and dispensing medical care, it is obvious that nearly all of those who claim familiarity with the technical problems of the subject and mention the experiences gained abroad are themselves in favor of government intervention in the financing and distribution of medical care.

Published knowledge based on convictions are, however, very different in those countries which have had long experience, in some instances of several generations, with any sort of compulsory health insurance of governmental control of the medical services. Certainly opinions are sharply different in countries where the object of discussion is no longer a hoped for ideal arrangement but an entrenched institution and often one of the most powerful organizations in the nation. One generalization which can be made confidently about all the "experiments" is that the results have differed widely from and have generally fallen short of the expectations which lead to their adoption. The many unforeseen effects which have developed point out that only by actual experience does the public become aware of the problems inherent in all proposals for government sponsored medical care systems. Given the character of the demand for medical services, the need to adjust supply to it, and the effects on peoples' habits — not to speak of total cost — these systems have regularly turned out to be different from what had been expected.

It is a difficult task to obtain sober and reliable evaluations or assessments of programs which have been monopolized by governments whose social philosophy is generally favored by fashionable political opinion and certain official international organizations. For a people not yet committed to such developments it is most important to be fully aware of both sides of the coin.

This book reads easily and should be read by all concerned with the future of medical care and the medical profession in the United States.

STANLEY D. SIMON, M.D.

THORACIC DISEASES. Emphasizing Cardiopulmonary Relationships by Eli H. Rubin, M.D. and Morris Rubin, M.D. In Association with George C. Leiner, M.D. and Doris J. W. Escher, M.D. W. B. Saunders Co., Phil., 1961. $25.00.

This well-written book of 968 pages, has 13 sections and 53 chapters. The first three sections are devoted to anatomy, chest X-ray, and cardiopulmonary physiology. In the remaining sections various pulmonary problems such as perinatal respiratory diseases, intrathoracic anomalies, pneumonias and pulmonary suppurations, bronchial obstructions, intrathoracic neoplasms, tuberculosis, pneumoconiosis, thoracic manifestation of systemic diseases, diseases of pleura, and thoracic injuries are discussed.

Although the main emphasis is placed on pulmonary diseases and its related problems, the cardiopulmonary relationships are carefully integrated throughout the book. The sections in pulmonary physiology and cardiac catherization are brief and short. Chapters on pulmonary tuberculosis and carcinoma are excellent, well written and up to date, with many illustrations. The most valuable part of this book is the bibliography and numerous references at the end of each chapter. Four hundred sixty-one illustrations, mainly X-rays, make the reader aware of the importance of radiological findings in the diagnosis of pulmonary problems.

As a whole, this is an excellent book for those who are interested in the diseases of the chest.

JOHN YASHAR, M.D.

concluded on next page

LIFE INSURANCE or DEATH INSURANCE?

SOME Medical men need DEATH Insurance ONLY.

Others need accumulating, guaranteed dollar values to meet their LIVING needs in the future — DEPRESSION — EMERGENCY — RETIREMENT, etc.

In any event, our new "CHEAPER-THAN-TERM" DEATH INSURANCE is the first step in the right direction!

Don't make any important changes in your Life Insurance or Estate plans without investigating "CHEAPER-THAN-TERM"!

For further information about this sensational new development in DEATH INSURANCE, write or phone:

ROLAND A. DEROSIER
54 Custom House Street
Providence 3, Rhode Island
TE 1-4833

"your very good health"



A. B. MUNROE DAIRY
Robert E. Armstrong
EAST PROVIDENCE, R.I.

In pediatrics . . . in geriatrics . . . and all the years between — Milk — Nature's most nearly perfect food, figures prominently in the balanced diet.

For you, your family and your patients, the A. B. Munroe Dairy produces the finest milk available. Fortified with Vitamin D, processed in immaculate surroundings, conforming to stringent quality requirements, A. B. Munroe milk is the ultimate in purity and safety.

ASSOCIATION MEMBER

A. B. MUNROE DAIRY, INC.
151 Brow Street, East Providence, Rhode Island

Call GE 8-4450
for Home Delivery

DOCTORS' DILEMMAS by Louis Lasagna, M.D. Harper & Brothers, N.Y., 1962. $4.95

The title of this entertainingly-written review of a broad spectrum of medical topics is somewhat misleading. It would lead one to believe that it describes moral problems encountered by physicians, which present a difficult choice of the nature of the dilemma imposed upon the protagonist of George Bernard Shaw's drama.

While the author does pose many of the problems encountered by the physician in these parlous times, they are not of the type which can be settled by his decisive action in one or the other direction. Rather these are more the problems that have been thrust upon the profession — such as quackery, the malpractice suit racket, sensational medical articles in the lay press, and cultism. Doctor Lasagna does not constitute himself a defender of the medical profession, however, and has some sharp remarks about surgical fees, psychoanalysts, and the tendency of some specialty boards to act as guilds in order to "restrict recognition to an elite few who adhere to a strict formula of training."

The subjects include a brief review of medical history as typified by the "medical giants," caustic descriptions of ancient and contemporary quackeries, the attitudes of the various religions towards medical-ethical questions, comments upon medical education, and many more assorted subjects without any particular inter-relationship except insofar as physicians are in some way involved.

There is a smart-alecky color to the subtopics reminiscent of TIME MAGAZINE with its free use of racy prose, punning, alliteration, rhyming, and tabloid headline-type questions. Examples are: "The Markle Sparkle," "Medicine Avenue," "Was Leonardo a homosexual?" (not answered, by the way), "Knifesmanship," and "From safety belts to prostitution."

The author's conclusions appear, on the whole, sound; and if the contemporary journalistic style attracts more readers, the better for their knowledge of medicine in the past, some aspects of its present status, and its future possibilities.

IRVING A. BECK, M.D.

TUES., NOV. 6–THURS., NOV. 8 . . . N.E. Postgraduate Assembly. At Boston Statler Hotel.

MON., NOV. 26–FRI., NOV. 30 . . . Clinical Session, American Medical Association, at Los Angeles, Calif.

MON., DEC. 3 . . . Scientific Meeting. Providence Medical Association. At the Medical Library, 8:30 P.M.

MON., JAN. 7, 1963 . . . ANNUAL MEETING. Providence Medical Association. At the Medical Library, 8:30 P.M.

A MODERN ROMAN CIRCUS

(The title above is ours, but the observations set forth below from a guest editorial by William S. McNary, executive vice president of Michigan Hospital Service, which appeared in the Blue Cross Association EXCHANGE (Vol. II, No. 7, August, 1962), are so pertinent to the local scene that they might have been written about Rhode Island. We feel it appropriate that they be given wider circulation in this area. — THE EDITOR)

IN THE HEYDAY of the Roman Empire, a popular sport was that of enlivening the regular schedule of gladiatorial combat by putting a few dozen early-day Christians into an arena and releasing among them a suitable number of half-starved lions.

History has seen other examples of the "Roman Circus," although they have been refined with the passage of time. There are no longer arenas, but public castigation by inference and innuendo is still a cruel form of torture.

One manifestation of this public pillory which has swept the eastern and midwestern sections of this country, beginning in the middle 1950's has been the Blue Cross Rate Hearing. As a result of some of these legislative investigations, many reputable citizens have had their names and reputations needlessly endangered.

Blue Cross was new, it was relatively defenseless, and its spokesmen were few in number. In short, it was fair game for the politician, the rabble rouser, and for anyone who had a real or imagined grievance against hospitals or doctors.

The fact that no scandals or embezzlements had ever been imputed to the individual Plans which were attacked did not seem important to those who took the adversary role. Neither did the fact that Blue Cross, as an institution, was performing an important public service and had, in a very real sense, lifted itself by its own bootstraps to do a desperately needed job.

Blue Cross handled a lot of the public's and the hospitals' money; Blue Cross costs were going up more rapidly than most other costs; a lot of people belonged to Blue Cross, disliked paying more money and were quite willing to believe that something must be wrong.

Hearing after hearing was held in city after city and state after state. These included one-day hearings, three-day hearings, recessed hearings, and hearings which were repeated in other cities.

Little useful data or information has been obtained in this way. The responsible state departments either had, or had access to, all pertinent information without hearings. Business, labor and public officials could get similar data for the asking. Reporters for local and national publications were welcomed by Plans and their questions were readily and honestly answered.

What has been accomplished by most of these hearings — other than denigration of a fine and honorable community service — is hard to say. It may well be that the injustice, futility and waste inherent in such spectacles have now become so apparent that the practice will be abandoned or at least amended so that most future hearings will be fair or constructive — or both.

This hope is given strength by one of the comments in the Michigan Report of the Governor's Study Commission on Prepaid Hospital and Medical Care Plans just released. This report says in part: "... From an actuarial viewpoint, public hearings are of doubtful value, as the unproved charges raised by vocal opponents of rate increases may outweigh the benefits obtained through free public discussion of the problem."

It is devoutly to be hoped that our state officials will find it is in the public interest to do away with this particular modern Roman Circus.

We Offer the Finest Facilities for
CONVENTIONS, SEMINARS, CONFERENCE MEETINGS
1 to 400 persons
NEW MOTOR INN and ALL FUNCTION ROOMS
FULLY AIR-CONDITIONED
Outdoor Swimming Pool, Boating, Fishing, Golfing,
Historic Mansions, World Famous Ocean Drive
Viking Hotel and Motor Inn
"in the center of everything"
NEWPORT, RHODE ISLAND
Telephone 847-3300

Patronize Journal Advertisers

RHODE ISLAND DEPARTMENT OF HEALTH PROVISIONAL VITAL STATISTICS

January-June, 1962

JOSEPH E. CANNON, M.D., M.P.H., Director of Health, *and*
LERA L. O'HARA, Chief, Division of Vital Statistics

PROVISIONAL VITAL STATISTICS for the first half of 1962 are based on the records filed through June for events occurring in Rhode Island, regardless of the place of residence. Comparable data for the first six months of 1961 are presented to indicate short-run changes in these vital events. The rates are computed on an annual basis and certain rates are based on population estimates obtained by the addition of the estimated natural increase to the 1960 census enumeration.

Births

Rhode Island registered 350 fewer live births in the first half of 1962 than in the same period of 1961 (Table I). Nearly a five per cent decline occurred between the 1961 birth rate of 21.9 and the 1962 rate of 20.9 per 1,000 estimated population.

Marriages

The marriage rate (5.9) in 1962 was practically the same as the rate of 5.8 per 1,000 population for January-June 1961, as shown in Table I. Seventy-three more marriages were performed in the state during the first half of 1962 than in 1961, an increase of nearly three per cent.

TABLE I

Vital Statistics: Rhode Island, January-June, 1961 and 1962

Item	Number			Rate		
	1962	1961	Per Cent Change	1962	1961	Per Cent Change
*Live Births	9,102	9,452	—3.7	20.9	21.9	—4.6
*Marriages	2,570	2,497	+2.9	5.9	5.8	+1.7
*Deaths	4,619	4,404	+4.9	10.6	10.2	+3.9
†Infant Deaths	243	205	+18.5	26.7	21.7	+23.0
†Neonatal Deaths	186	153	+21.6	20.4	16.2	+25.9
‡Fetal Deaths	339	157	+115.9	37.2	16.6	+124.1

*Rate per 1,000 population

†Rate per 1,000 live births

Infant Deaths

The infant mortality rate during the first six months of 1962 (26.7 per 1,000 live births) rose 23 per cent above the rate for the equivalent 1961 period (Table I). There were 38 more infant deaths in 1962; 33 of this increase occurred during the first 27 days of life. When pneumonia of the newborn is included with other infant deaths from pneumonia, the 1962 rate (3.7 per 1,000 live births) more than doubled the 1961 rate (1.7); this rise continued an upward trend evident since 1957 in Rhode Island.

Fetal Deaths

The 339 fetal deaths registered in the first half of 1962 more than doubled those reported in the corresponding six months of 1961; the ratio per 1,000 live births increased from 16.6 to 37.2 (Table I).

Deaths and Principal Causes of Death

The mortality rate per 1,000 population increased by nearly four per cent between the first half of 1961 (10.2) and of 1962 (10.6), as shown in Table I. The number of deaths rose by 215 in total. Among the ten principal causes presented in Table II, heart disease, malignant neoplasms, vascular lesions, diseases of early infancy, pneumonia, and arteriosclerosis had considerably more deaths in 1962 than in 1961. Only a slight increase (four deaths) occurred from other circulatory diseases, while deaths from diabetes, cirrhosis of liver, and accidents declined. As Table III shows, the motor-vehicle fatalities in the first six months of 1962 exceeded 1961 by five, but all other accidental deaths decreased by 16, including 13 fewer deaths from home accidents.

TABLE II

Deaths and Death Rates per 100,000 Population from Ten Principal Causes of Death: Rhode Island, January-June, 1961 and 1962

1962 Rank	Cause of Death	1962 Number	1962 Rate	1961 Number	1961 Rate
1.	Diseases of the heart (410-443)	2,088	479.3	1,995	463.0
2.	Malignant neoplasms (140-205)	800	183.6	753	174.7
3.	Vascular lesions (330-334)	446	102.4	423	98.2
4.	Accidents (800-962)	158	36.3	169	39.2
5.	Diseases of early infancy (760-776)	154	35.4	121	28.1
6.	Influenza and pneumonia (480-493)	133	30.5	99	23.0
7.	Diabetes mellitus (260)	103	23.6	145	33.6
8.	General arteriosclerosis (450)	83	19.1	47	10.9
9.	Other diseases of circulatory system (451-468)	62	14.2	58	13.5
10.	Cirrhosis of liver (581)	59	13.5	71	16.5

Table III presents the provisional number of deaths from selected causes with rates for the first half of 1961 and 1962. A more detailed breakdown is available upon request.

TABLE III

Provisional Numbers of Deaths from Selected Causes
Rhode Island, January-June, 1961 and 1962
(Excludes fetal deaths. Rates per 100,000 estimated population except as noted)

Cause of Death (Seventh Revision of the International Lists, 1955)	1962 Number	1962 Rate	1961 Number	1961 Rate
All Causes†	4,619	10.6	4,404	10.2
Tuberculosis, all forms (001-019)	15	3.4	17	3.9
Syphilis and its sequelae (020-029)	2	0.5	6	1.4
Dysentery, all forms (045-048)	....	....	2	0.5
Scarlet fever and streptococcal sore throat (050, 051)	....	....	....	....
Meningococcal infections (057)	1	0.2	2	0.5
Acute poliomyelitis (080)	....	....	....	....
Encephalitis (082)	2	0.5	....	....
Measles (085)	2	0.5	....	....
Infectious hepatitis (092)	....	....	3	0.7
Malignant neoplasms (140-205)	800	183.6	753	174.7
Asthma (241)	14	3.2	19	4.4
Diabetes mellitus (260)	103	23.6	145	33.6
Meningitis, except meningococcal and tuberculous (340)	6	1.4	8	1.9
Cardiovascular-renal diseases (330-334, 400-468, 592-594)	2,763	634.2	2,595	602.2
Vascular lesions (330-334)	446	102.4	423	98.2
Rheumatic fever (400-402)	4	0.9	1	0.2
Diseases of heart (410-443)	2,088	479.3	1,995	463.0
Hypertension without mention of heart (444-447)	45	10.3	40	9.3
General arteriosclerosis (450)	83	19.1	47	10.9
Other diseases of circulatory system (451-468)	62	14.2	58	13.5
Chronic and unspecified nephritis (592-594)	35	8.0	31	7.2
Influenza (480-483)	....	....	2	0.5
Pneumonia (490-493)	133	30.5	97	22.5
Bronchitis (500-502)	13	3.0	16	3.7
Ulcer of stomach and duodenum (540, 541)	32	7.3	25	5.8
Appendicitis (550-553)	4	0.9	3	0.7
Hernia and intestinal obstruction (560, 561, 570)	25	5.7	23	5.3
Gastritis, enteritis, etc. (543, 571, 572)	18	4.1	16	3.7
Cirrhosis of liver (581)	59	13.5	71	16.5
Cholelithiasis, cholecystitis, and cholangitis (584, 585)	9	2.1	23	5.3
Acute nephritis and nephrosis (590, 591)	3	0.7	4	0.9
Infections of kidney (600)	22	5.1	14	3.2
Hyperplasia of prostate (610)	8	1.8	7	1.6
Complications of pregnancy, childbirth, etc.* (640-689)	....	....	2	2.1
Congenital malformations (750-759)	56	12.9	56	13.0
Certain diseases of early infancy (760-776)	154	35.4	121	28.1
Symptoms, senility and ill-defined conditions (780-795)	11	2.5	7	1.6
Accidents (800-962)	158	36.3	169	39.2
Motor-vehicle accidents (810-835)	45	10.3	40	9.3
All other accidents (800-802, 840-962)	113	25.9	129	29.9
Occurring in home (870-936, .0)	64	14.7	77	17.9
Suicide (963, 970-979)	20	4.6	23	5.3
Homicide (964, 980-985)	4	0.9	10	2.3

† Rate per 1,000 population
* Rate per 10,000 live births

ON THE MEDICAL LIBRARY BOOKSHELVES

The following titles have been added to the James H. Davenport Collection through purchase and gift:

MINDS THAT CAME BACK by Walter C. Alvarez, M.D. with an Introduction by Hervey M. Cleckley, M.D. J. B. Lippincott Co., Phil., 1961.

ONE FOR A MAN, TWO FOR A HORSE. A Pictorial History, Grave and Comic, of Patent Medicines by Gerald Carson. Doubleday & Co., Inc., Garden City, N.Y., 1961.

BEST PLAYS by Chekhov. The Sea Gull. Uncle Vanya. The Three Sisters. The Cherry Orchard. Translated, and with an Introduction, by Stark Young. The Modern Library, N.Y., 1956.

PIONEERING IN PUBLIC HEALTH FOR FIFTY YEARS by the Committee on Public Health of the New York Academy of Medicine. Twenty Year Report of Its Activities, 1941-1961. Prepared by H. D. Kruse, M.D. and Lois Stice. N.Y., 1961.

A MIRROR UP TO MEDICINE by A. C. Corcoran, M.D. With a Preface by Allan Nevins. J. B. Lippincott Co., Phil., 1961.

HOSPITALS, DOCTORS, AND DOLLARS. Reports and Opinions on Our Good Samaritans, Who Are Having Some Bad Times by Robert M. Cunningham, Jr. F. W. Dodge Corporation, N.Y., 1961.

BROTHERLY LOVE by Gabriel Fielding. William Morrow & Co., N.Y., 1961.

DISEASE AND DESTINY. A Bibliography of Medical References to the Famous by the late Judson Bennett Gilbert, M.D. With Additions and an Introduction by Gordon E. Mestler. Preface by Emerson C. Kelly, M.D. Dawsons of Pall Mall, Lond., 1962.

SERENGETI SHALL NOT DIE by Bernhard and Michael Grzimek. With an Introduction by Alan Moorehead. Translated from the German by E. L. and D. Rewald. E. P. Dutton & Co., Inc., N.Y., 1961.

LECTURES ON THE WHOLE OF ANATOMY by William Harvey. An Annotated Translation of *Prelectiones Anatomiae Universalis* by C. D. O'Malley, F. N. L. Poynter and K. F. Russell. University of California Press, Berkeley, 1961.

THE GREAT EPIDEMIC by A. A. Hoehling. Little, Brown, and Co., Bost., 1961.

LAENNEC. His Life and Times by Roger Kervran. Translated from the French by D. C. Abrahams-Curiel. Pergamon Press, 1960.

DR. TIMOTHIE BRIGHT. 1550-1615. A Survey of His Life with a Bibliography of His Writings by Geoffrey Keynes. The Wellcome Historical Medical Library, Lond., 1962.

WILLIAM RIMMER: His Life and Art by Lincoln Kirstein. In MR: Massachusetts Review, 2:685-716, Summer, 1961. *Gift of Mr. Antonio Cirino.*

TIBERIUS. The Resentful Caesar by Gregorio Marañón. With a Foreword by Ronald Syme. Translated from the Spanish by Warre Bradley Wells. Duell, Sloan and Pearce, N.Y., 1956. *Gift of Francesco Ronchese,* M.D.

MAUGHAM'S CHOICE OF KIPLING'S BEST. Sixteen Stories Selected and with an Introductory Essay by W. Somerset Maugham. Doubleday & Co., Inc., Garden City, 1953. *From the Estate of Maurice H. Caldwell.*

WITCH DOCTOR'S APPRENTICE by Nicole Maxwell. Riverside Press, Cambridge, Mass., 1961.

THE MOVIEGOERS by Walker Percy. Alfred A. Knopf, N.Y., 1962.

IPPOLITA by Alberto Denti di Pirajno. Doubleday & Co., Inc., Garden City, 1961.

MENTAL HEALTH IN THE UNITED STATES. A Fifty-Year History by Nina Ridenour, PH.D. Published for the Commonwealth Fund by the Harvard University Press, Cambridge, Mass., 1961.

I SANTI E I DÈMONI by Alessandro Simili. Licinio Cappelli Editore. Bologna, 1952. *Gift of Francesco Ronchese,* M.D.

MEDICAL HISTORY, HUMANISM AND THE STUDENT OF MEDICINE by Henry R. Viets, M.D. Dartmouth Publications, Hanover, N.H., 1960.

THE FARMERS' DAUGHTERS. The Collected Stories of William Carlos Williams. Introduction by Van Wyck Brooks. New Directions Book, Norfolk, Conn., 1961.

A GATHERING FOR WILLIAM CARLOS WILLIAMS by various authors. MR: Massachusetts Review 3:277-344, Winter, 1962.

continued on page 536

your patient becomes



tractable

with

Trancopal®

(brand of chlormezanone)

effective tranquilizer and skeletal muscle relaxant

THE TRUE "TRANQUILAXANT"
FOR A RELAXED MIND IN A RELAXED BODY

- **quiets the anxiety of the tense patient**
- **eases tense muscles, relaxes the patient**
- **reported side effects are rare and usually mild.**

AVAILABLE: 200 mg. Caplets® (green colored, scored), 100 mg. Caplets (peach colored, scored), each in bottles of 100.

DOSAGE: Adults, 1 Caplet (200 mg.) three or four times daily; children (5 to 12 years), from 50 to 100 mg. three or four times daily.

Before prescribing, consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

Winthrop LABORATORIES, New York 18, N. Y.

1728M

ON THE MEDICAL LIBRARY BOOKSHELVES

continued from page 534

Through the generosity of the Rhode Island Veterinary Medical Association, we have been able to purchase the following books:

A SHORT HISTORY OF VETERINARY MEDICINE IN AMERICA by B. W. Bierer. Michigan State University Press, East Lansing, 1955.

THE INFECTIOUS DISEASES OF DOMESTIC ANIMALS. With Special Reference to Etiology, Diagnosis, and Biologic Therapy by William A. Hagan, D.V.M. and Dorsey W. Bruner, D.V.M. 4th ed. Comstock Publishing Associates, Ithaca, N.Y., 1961.

ORTHOPEDIC SURGERY OF THE DOG AND CAT by Ellis P. Leonard, D.V.M. W. B. Saunders Co., Phil., 1960.

MAN AND DOLPHIN by John C. Lilly, M.D. Doubleday & Co., Inc., Garden City, N.Y., 1961.

COMPARATIVE MEDICINE IN TRANSITION. Proceedings of the First Institute on Veterinary Public Health Practice, October 6-9, 1958, University of Michigan School of Public Health, Ann Arbor, Michigan, 1960.

VETERINARY PATHOLOGY by Hilton A. Smith, D.V.M. and Thomas C. Jones, D.V.M. Lea & Febiger, Phil., 1961.

HANDBOOK OF BIOLOGICAL DATA. Edited by William S. Spector. Prepared Under the Direction of the Committee on the Handbook of Biological Data, Division of Biology and Agriculture, The National Academy of Sciences, The National Research Council. W. B. Saunders Co., Phil., 1956.

In addition to the textbooks listed above, the Library is receiving a subscription to the JOURNAL OF THE AMERICAN VETERINARY MEDICAL ASSOCIATION and gifts of other periodicals from Doctors Morris and Ralph Povar.

The following texts were added to the Charles F. Gormly Collection of legal medicine, which is maintained by Mrs. Gormly:

DISEASE AND INJURY. Edited by Leopold Brahdy, M.D. J. B. Lippincott Co., Phil., 1961.

LAW AND MEDICINE. Text and Source Materials on Medico-Legal Problems by William J. Curran, LL.D. Little, Brown & Co., Bost., 1960.

Purchases made through the Society's funds were as follows:

ADMISSION REQUIREMENTS OF AMERICAN MEDICAL COLLEGES INCLUDING CANADA, 1961-62. Compiled by Helen Hofer Gee and E. Shepley Nourse. Association of American Medical Colleges, Evanston, Ill., 1962.

AMERICAN MEDICAL DIRECTORY, 1960-61. 21st ed. American Medical Association, Chic., 1961.

TEXTBOOK OF PATHOLOGY. An Introduction to Medicine by William Boyd, M.D. 7th ed. Lea & Febiger, Phil., 1961.

DIRECTORY OF MEDICAL SPECIALISTS Holding Certification by American Specialty Boards, vol. 10. Marquis-Who's Who, Chic., 1961.

STANDARD NOMENCLATURE OF DISEASES AND OPERATIONS. Edward T. Thompson, Editor and Adaline C. Hayden, Associate Editor. Published for the American Medical Association, The Blakiston Division, McGraw-Hill Book Co., Inc., N.Y., 1961.

MODERN OCCUPATIONAL MEDICINE. A. J. Fleming, M.D. and C. A. D'Alonzo, M.D., Editors; J. A. Zapp, PH.D., Associate Editor. 2nd ed. Lea & Febiger, Phil., 1960.

THE CHOICE OF A MEDICAL CAREER. Essays on the Fields of Medicine by Joseph Garland, M.D. and Joseph Stokes, III, M.D. J. B. Lippincott Co., Phil., 1961.

HUMAN DISSECTION. Its Drama and Struggle by A. M. Lassek, M.D. Charles C. Thomas, Publisher, Springfield, Ill., 1958.

EPILEPSY AND RELATED DISORDERS by William G. Lennox, M.D. With the Collaboration of Margaret A. Lennox, M.D. 2 vols. Little, Brown & Co., Bost., 1960.

ADVANCES IN BIOLOGY OF SKIN. Vol. 1. Cutaneous Innervation by William Montagna. Pergamon Press—Symposium Publications Division. N.Y., 1960.

COMPARATIVE ANATOMY by William Montagna. John Wiley & Sons, Inc., N.Y., 1960.

SURGERY. A Concise Guide to Clinical Practice. Edited by George L. Nardi, M.D. and George D. Zuidema, M.D. By 23 Authors. Little, Brown & Co., Bost., 1961.

Novak's TEXTBOOK OF GYNECOLOGY by Edmund R. Novak, M.D. and Georgeanna S. Jones, M.D. 6th ed. Williams & Wilkins Co., Balt., 1961.

TREATMENT OF CANCER AND ALLIED DISEASES, Vol. V. Tumors of the Gastrointestinal Tract, Pancreas, Biliary System and Liver. Edited by George T. Pack, M.D. and Irving M. Ariel, M.D. Paul B. Hoeber, Inc. (Harper & Bros.), N.Y., 1962.

GYNECOLOGIC ENDOCRINOLOGY by Gardner M. Riley, M.D. Paul B. Hoeber, Inc. (Harper & Bros.), N.Y., 1960.

A HISTORY OF MEDICINE by Henry E. Sigerist, M.D. Vol. 2. Early Greek, Hindu, and Persian Medicine. Oxford University Press, N.Y., 1961.

MAN'S PRESUMPTUOUS BRAIN. An Evolutionary Interpretation of Psychosomatic Disease

by A. T. W. Simeons, M.D. E. P. Dutton & Co., Inc., N.Y., 1961.

PROGRESS IN NEUROLOGY AND PSYCHIATRY. An Annual Review. Vol. 16. Edited by E. A. Spiegel, M.D. Grune & Stratton, N.Y., 1961.

DICTIONARY OF ABBREVIATIONS IN MEDICINE AND THE RELATED SCIENCES by Edwin B. Steen, PH.D. F. A. Davis Co., Phil., 1960.

TREATMENT OF EMOTIONAL PROBLEMS IN OFFICE PRACTICE by Frank T. Tallman, M.D. Blakiston Division, McGraw-Hill Book Co., Inc., N.Y., 1961.

THE HEART IN INDUSTRY by Twenty-four Authors. Edited by Leon J. Warshaw, M.D. Paul B. Hoeber, Inc. (Harper & Bros.), 1960.

Williams OBSTETRICS by Nicholson J. Eastman, M.D. and Louis M. Hellman, M.D. 12th ed. Appleton-Century-Crofts, Inc., N.Y., 1961.

DIABETES. With a Chapter on Hypoglycemia. By 54 Authors. Edited by Robert H. Williams, M.D. Paul B. Hoeber, Inc. (Harper & Bros.), N.Y., 1960.

CLINICAL HEMATOLOGY by Maxwell M. Wintrobe, M.D. 5th ed. Lea & Febiger, Phil., 1961.

THE YEAR BOOK OF CANCER (1960-61 ser.). Compiled and Edited by Randolph L. Clark, Jr., M.D. and Russell W. Cumley, PH.D. Year Book Medical Publishers, Inc., Chic., 1961.

THE YEAR BOOK OF DRUG THERAPY (1960-61 ser.). Edited by Harry Beckman, M.D. Year Book Medical Publishers, Inc., Chic., 1961.

THE YEAR BOOK OF ENDOCRINOLOGY (1960-61 ser.). Edited by Gilbert S. Gordan, M.D. Year Book Medical Publishers, Inc., Chic., 1961.

THE YEAR BOOK OF GENERAL SURGERY (1961-62 ser.). Edited by Michael E. DeBakey, M.D. With a Section on Anesthesia Edited by Stuart C. Cullen, M.D. Year Book Medical Publishers, Inc., Chic., 1961.

THE YEAR BOOK OF MEDICINE (1961-62 ser.). Edited by Paul B. Beeson, M.D. and Others. Year Book Medical Publishers, Inc., Chic., 1961.

THE YEAR BOOK OF ORTHOPEDICS AND TRAUMATIC SURGERY (1960-61 ser.). Edited by H. Herman Young, M.D. With a Section on Plastic Surgery Edited by Neal Owens, M.D. Year Book Medical Publishers, Inc., Chic., 1961.

THE YEAR BOOK OF PATHOLOGY AND CLINICAL PATHOLOGY (1960-61 ser.). Edited by William B. Wartman, M.D. Year Book Medical Publishers, Inc., Chic., 1961.

continued on next page



On Her Birthday...

There'll be stars in her eyes . . when you wrap her in an irresistible Harris Mink scarf, stole, jacket or coat!

WILLIAM H. Harris

New England's Largest Exclusive Furrier
400 Westminster Street
One-Half Century of Fine Fur Tradition

E. P. ANTHONY, INC.
Druggists

WILBUR E. JOHNSTON, Phar. D.
RAYMOND E. JOHNSTON, B.S.

178 ANGELL STREET
PROVIDENCE, R. I.
GAspee 1-2512
Pharmacy License #225

J. E. BRENNAN & COMPANY
Leo C. Clark, Jr., B.S., Reg. Pharm.

Apothecaries

Two Convenient Locations
5 North Union Street — Pawtucket, R. I.
140 Central Avenue — Seekonk, Mass.
7 Registered Pharmacists
Pharmacy License #226

The Friends of our Library have been very generous with their gifts and we are grateful for their contributions:

The following Fellows donate periodicals or subscriptions regularly: Doctors John T. Barrett, Reuben C. Bates, Irving A. Beck, William P. Buffum, Alex M. Burgess, Francis H. Chafee, Francis V. Corrigan, Americo DelSelva, Donald L. DeNyse, John E. Farley, Seebert J. Goldowsky, Erwin O. Hirsch, Manuel Horwitz, Walter S. Jones, Louis I. Kramer, Jay M. Orson, John D. Pitts, Francesco Ronchese, Stanley Simon, Elihu S. Wing, Sr. and Elihu S. Wing, Jr.

Other contributors to our serials collection are: Mr. John E. Farrell, American Association of Genito-Urinary Surgeons, American Cancer Society (Rhode Island Division), American Clinical and Climatological Association, Association of American Physicians, Association of Life Insurance Medical Directors of America, British Government, Butler Health Center, Charles V. Chapin Hospital, Chicago Medical Society, Industrial Medical Association, Institute for Cancer Research, Institute of Life Insurance, National Foundation, National Institute of Health, National Kidney Disease Foundation, National Medical Library of Czechoslovakia, Pawtucket Memorial Hospital, Peters House Library, Providence Health Department, Providence Lying-In Hospital, Providence Medical History Club, Rhode Island Arthritis and Rheumatism Foundation, Rhode Island Chapter of the American Physical Therapy Association, Rhode Island Department of Health, Rhode Island Heart Association, Rhode Island Hospital, Rhode Island Tuberculosis and Health Association, Rockefeller Foundation, Roger Williams General Hospital, St. Joseph's Hospital, Smith Kline & French, State of Connecticut, State Health Library (R.I. Department of Health), Tobacco Industrial Research Committee, United States Department of Agriculture, United States Pharmacopeil Convention, Veterans Administration Regional and National Offices and Veterans Administration Hospital (Providence), and the Wilmer Ophthalmological Institute.

Large gifts were received from the following:

From the Estate of Herbert H. Armington, M.D. — 54 books, 2 letters and pamphlets.

Gift of Irving A. Beck, M.D.—21 books and reprints.

Gift of Alex M. Burgess, Sr. and Alex M. Burgess, Jr. — 250 books and pamphlets.

From the Estate of Dr. Leo E. Deslandes (Given by his sister, Mrs. Lea C. Trottier) — 33 books.

From the Estate of Frank T. Fulton, M.D. *(Given by Marshall Fulton,* M.D.*)* — 200 books and pamphlets.

Gift of Anne L. Lawton, M.D. — 226 books.

Gift of Mrs. Ernest C. Maby — 122 books which belonged to her grandfather, Benjamin I. C. Buckland, M.D., of Fleming, N.Y., and his father.

Gift of Mr. Marius F. Paulin — 9 books.

Gift of John D. Pitts, M.D. — *22* books.

From the Library of Albert W. Rounds, M.D. — 10 books.

Gift of H. Frederick Stephens, M.D. — 207 books and pamphlets, most of which had been in the library of George W. Van Benschoten, M.D.

Gift of John R. Stuart, M.D. — 19 books.

Gift of Elihu S. Wing, Sr. and Elihu S. Wing, Jr. — 64 books and bound periodicals.

Other gifts were:

From Samuel Adelson, M.D. — LETTERS TO A YOUNG PHYSICIAN JUST ENTERING UPON PRACTICE by James Jackson, M.D. Phillips, Sampson & Co., Bost., 1855.

From Ivan Basilevich, M.D. — THE MEDICAL ASPECTS OF NATURAL OLD AGE. An Introduction to Clinical Gerontology by Ivan Basilevich, M.D. Munich, 1959.

From William P. Buffum, M.D. — CHILD HEALTH SERVICES AND PEDIATRIC EDUCATION. Report of the Committee for the Study of Child Health Services, The American Academy of Pediatrics with the Co-operation of the United States Public Health Service and the United States Children's Bureau. The Commonwealth Fund, N.Y., 1949.

— THE YEAR BOOK OF PEDIATRICS, Chic., 1951-1960.

From James H. Cassedy — EDWIN MILLER SNOW: An Important American Public Health Pioneer by James H. Cassedy, reprint, Bull. Hist. Med. v. 35, #2, March-April 1961.

From the Estate of John E. Donley, M.D. — CLINICAL NEUROSURGERY, Proceedings of the Congress of Neurological Surgeons, v. 2, New York, 1954. Williams & Wilkins Co., Balt., 1955.

From Mrs. Edwin G. Egge — PRIMITIVE PHYSIC: Or, An Easy and Natural Method of Curing Most Diseases by John Wesley. Revised and Enlarged by William M. Cornell. 24th ed. Bost., 1858.

From Martin Ekblad — THE PROGNOSIS AFTER STERILIZATION ON SOCIAL-PSYCHIATRIC GROUNDS. A Follow-up Study of 223 Women by Martin Ekblad. Copenhagen, 1961. Acta psychiat. scandinav. sup. 161, v. 37, 1961.

From John E. Farrell — DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS FOR 1962. Hearings Before the Subcommittee of the Committee on Appropriations, House of Representa-

concluded on page 540

The extra-firm mattress selected by over 9,000 doctors for their own use

Assures both preventive and corrective support—used in more American homes than any other special design

Sealy Posturepedic is the first mattress designed in cooperation with leading orthopedic surgeons to promote normal, healthful sleep among *all* persons.

As a "corrective device" it serves those chronically afflicted with lower back syndromes. As a preventive measure Sealy Posturepedic brings deep spring buoyancy without bedboard hardness to everyone—plus the concomitant blessings of unexcelled comfort and extra-firm support.

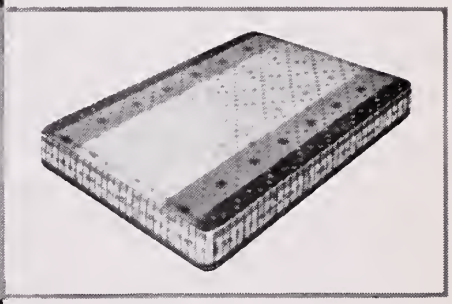
These are basic to good health. The therapeutic value of restful sleep is especially recognized during these tense and anxious days. Sealy Posturepedic eminently meets this need by supplying level spine support for proper relaxation of the limbs and human musculatory system.

Over 9,000 doctors of medicine have tried and bought the Sealy Posturepedic mattress and matching foundation for their own use. We believe your investigation will firmly convince you of its distinctive benefits, and, we would hope, merit your valued recommendation.

Sealy POSTUREPEDIC® BRAND

NO MORNING BACKACHE
from a too-soft mattress





PROFESSIONAL DISCOUNT OF $39.00

So that you may judge the quality of the Sealy Posturepedic for yourself, we offer a special Professional Discount on this mattress and foundation when purchased for your personal use. *Limit—one full or two twin size sets.*

SEALY MATTRESS COMPANY • Oakville, Conn.

Enclosed is my check and letterhead. Please ship the Sealy Posturepedic Set(s) indicated below:

1 Full Size ☐ **1 Twin Size** ☐ **2 Twin Size** ☐

	RETAIL		PROFESSIONAL
Posturepedic Mattress	each $79.50	(add state tax)	$60.00
Posturepedic Foundation	each $79.50	(add state tax)	$60.00

NAME_____

RESIDENCE_____

CITY_____ ZONE_____ STATE_____

(This is a saving of $39.00 per set over the regular $159.00 retail price for mattress and matching foundation)

© Sealy, Inc., 195

ON THE MEDICAL LIBRARY BOOKSHELVES

concluded from page 538

tives, Eighty-seventh Congress, First Session. 2 pts.

— DIGEST OF OFFICIAL ACTIONS, American Medical Association, 1846-1958. v. 1, Chic., 1959.

— DIRECTORY OF VOLUNTARY ORGANIZATIONS IN THE FIELD OF AGING. Report by the Subcommittee on Problems of the Aged and Aging to the Committee on Labor and Public Welfare, United States Senate, Eighty-sixth Congress, Second Session, December 1960.

From Marshall N. Fulton, M.D. — STORY OF THE HEART STATION AT THE RHODE ISLAND HOSPITAL by Frank T. Fulton, M.D. Prov., 1955.

From Seebert J. Goldowsky, M.D. — OFFICIAL REGISTER OF HARVARD UNIVERSITY, v. 59, #2, Feb. 20, 1962. Harvard Medical School and School of Dental Medicine, 1962.

— SURGICAL FORUM. Proceedings of the Forum Sessions, Forty-seventh Clinical Congress of the American College of Surgeons, Chicago, October 1961. v. XII. American College of Surgeons, Chic., 1961.

(To be concluded)

AIR AMBULANCE SERVICE

To any part of the country — day or night. Multi-engine equipment, air line rated pilots. Fully equipped ambulance, stimulant tray, oxygen therapy etc. Registered nurse on all trips. We can transport stretcher cases in and out of the smallest airports.

No increase in rates over ground transportation

CUSHMAN'S

AIR AMBULANCE SERVICE

47 NISBET ST., PROVIDENCE, RHODE ISLAND

Call DE 1-4840

THE PROFESSOR SHOULD INQUIRE OF PROFESSOR HAMMERSCHLAGER HOW TO GET A "GRANT"

Clapologist

The mechanics of handclapping have recently been studied in the laboratories of Professor Hieronymous Fläbbergast, who has come to the conclusion that basically there are only two methods of tonal projection: straight palm and curved palm. Using 750 volunteers, captured as they came from Carnegie Hall, and measuring their output with a square-wave oscilloscope in parallel with an audiometer, Professor Fläbbergast has described the results in a paper published in the Zeitschrift für Stimmungspielensingenmachenkuchenessenlaechelnweinen und Akustik.

According to Professor Fläbbergast, straight-palm clapping gives a sharper, clearer resonance, especially if the right hand is allowed to rebound from the left. This takes a little practice. Fingers must be closed, so that the air is smartly compressed. Not much shoulder action is necessary. The force should be applied by the forearm. But at the last instant the weight of the palm comes into play, like the head of a No. 1 wood off the tee. Just as the club head does the work, so in the straight-palm approach does the weight of the flipper.

Controlled Nuances

In the curved-palm method, the sound is less electric but (says Professor Fläbbergast) more mellow. Here tonal production can be varied to stimulate the larger pipes of an organ. Never let the hands rebound, however. The curved second joint of the fingers in the right hand should fit snugly over the leading edge of the left hand. With a little practice both palms can be arched, adding about an octave in the lower register.

Professor Fläbbergast advises soaking both hands in alum at least an hour daily. This, he thinks, is the best way to harden the skin.

"Concert artists," he says, "practice six hours a day. No? It is true that applauders need not so much practice. But a good applauder should practice at least two hours. Yes? One hour soaking, five minutes drying, ten minutes curved-palm, ten minutes straight-palm, and the rest interpretation. Of course the talented applauder might do with less. But for the average, two hours. And these should be hours of concentration. All artists must resist the temptation for practice to become rote. No?"

. . . Abstracted from *How to Applaud* by Harold C. Schonberg, in THE NEW YORK TIMES, September 15, 1962.



in arthritis: vitamins <u>are</u> therapy

In dealing with the chronic stress of arthritis the physician often faces the problem of nutritional imbalance. High potency B and C supplementation is needed for rapid replenishment of tissue stores of these water-soluble vitamins. STRESSCAPS meet this need and help support the natural metabolic defenses in the disease. Supplied in decorative "reminder" jars of 30 and 100.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

STRESSCAPS®

Stress Formula Vitamins Lederle



To help you and your family build systematically and surely for the future

A new type of trust service from Industrial National Bank

THE BUDGET TRUST

NOW INDUSTRIAL NATIONAL offers you a personal budget plan to help you build for the future — a budget plan you can start on right now! It's a new type of trust service — *The Budget Trust.*

How your Budget Trust works

You start your Budget Trust with $100 or more. Then you make regular planned deposits. It may be as little as $25 a month.

Your funds are invested in common stocks selected primarily with an eye to long-term growth rather than current income. Your lawyer draws the Trust Agreement — and Industrial National acts as your trustee. All income earned is added to your Budget Trust and reinvested. The continuous inflow of funds gives you the maximum advantage of dollar-cost-averaging.

Flexibility of your Budget Trust

Your Budget Trust is revocable at any time, in part or in whole. You may withdraw any part of your funds on quarterly withdrawal and entry dates.

You will discover, though, that a Budget Trust — with its systematic deposit feature — will make it much easier for you to accumulate the funds you need for your long-range goals. It's something important to consider when you think ahead to your retirement, your children's education, or any other years-from-now project.

Your Budget Trust brings you the benefits of Industrial National's broad investment and trust experience. One of our trust officers will be glad to discuss the new Budget Trust with you. To learn more about the Budget Trust, visit any Industrial National office, or call Mr. Allingham at JA 1-9700.

INDUSTRIAL
NATIONAL BANK OF
RHODE ISLAND

45 Neighborhood Offices Serving Rhode Island

Member Federal Reserve System
Member Federal Deposit Insurance Corporation

NOVEMBER, 1962

RHODE ISLAND

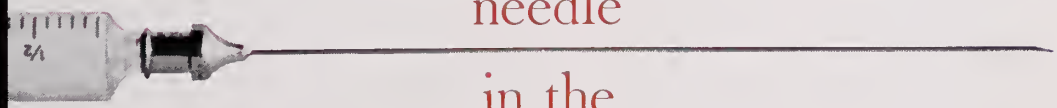
Medical Journal

Volume XLV, No. 11

Table of Contents, page 543

THE N Y ACAD OF MEDICINE DEC 11 1962 LIBRARY

the longest "needle" in the world



It never stings—needs no sterilizing. It reaches all the way from your office to the patient's home to give him potent penicillin therapy as often and as long as he needs it. It's an *oral* "needle," of course . . . V-Cillin K®. . . the penicillin that makes oral therapy as effective as intramuscular, but safer—and much more pleasant.

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly) (penicillin V potassium)

Sometimes your judgment dictates parenteral penicillin for your office patients. But to extend that therapy, take advantage of the longest "needle" in the world . . . V-Cillin K.

Tablets V-Cillin K, 125 or 250 mg. (scored).

V-Cillin K, Pediatric, 125 mg. per 5 cc., in 40 and 80-cc.-size packages.

This is a reminder advertisement. For adequate information for use, please consult manufacturer's literature. Eli Lilly and Company, Indianapolis 6, Indiana.

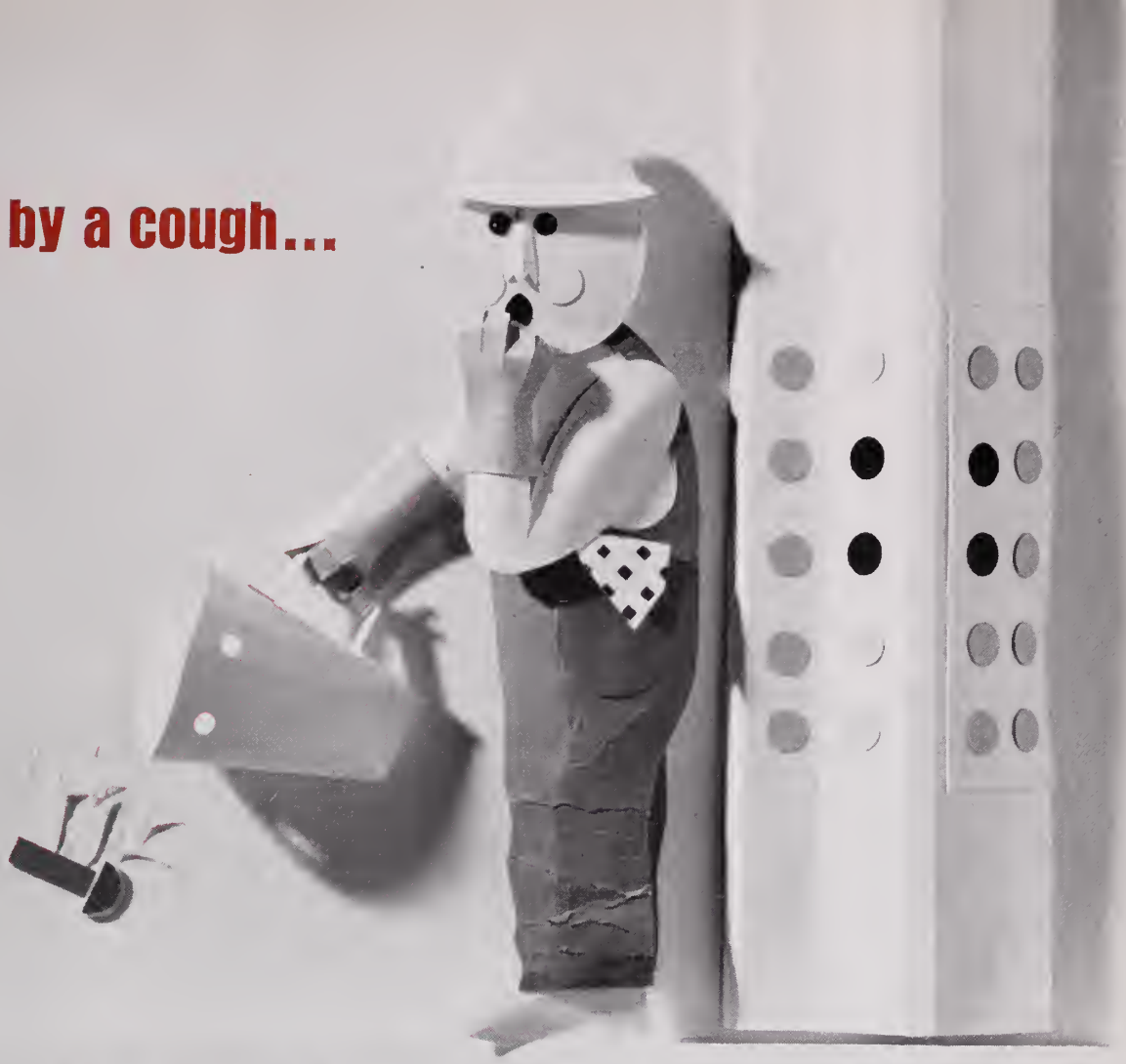
Lilly

233280

when the perfect combination



efeated by a cough...



Benylin®
Expectorant

ovides the right combination r effective cough control

r patient may not catch rivets for a living, but when he ches cold, coughing can lead to a catch-as-catch-can per- nance on his job. Not so when you prescribe BENYLIN ECTORANT. This outstanding antitussive preparation ctively suppresses coughs due to colds or allergy through combination of judiciously selected ingredients.

adryl,® a potent antihistaminic-antispasmodic, calms the gh reflex, relieves bronchial spasm, and reduces nasal stuffiness, sneezing, lacrimation, and other symptoms associated with colds and coughs of allergic origin. Efficient expectorants break down tenacious mucous secretions, thereby relieving respiratory congestion. And the pleasant-tasting, raspberry-flavored syrup provides a soothing demulcent action that eases irritated throat membranes.

BENYLIN EXPECTORANT contains in each fluid-ounce:

Benadryl® Hydrochloride (diphenhydramine hydrochloride, Parke-Davis)	80 mg.
Ammonium chloride	12 gr.
Sodium citrate	5 gr.
Chloroform	2 gr.
Menthol	1/10 gr.
Alcohol	5%

Supplied: BENYLIN EXPECTORANT is available in 16-ounce and 1-gallon bottles.

This advertisement is not intended to provide complete information for use. Please refer to the package label, medical brochure, or write for detailed information on indications, dosage, and precautions.

PARKE-DAVIS

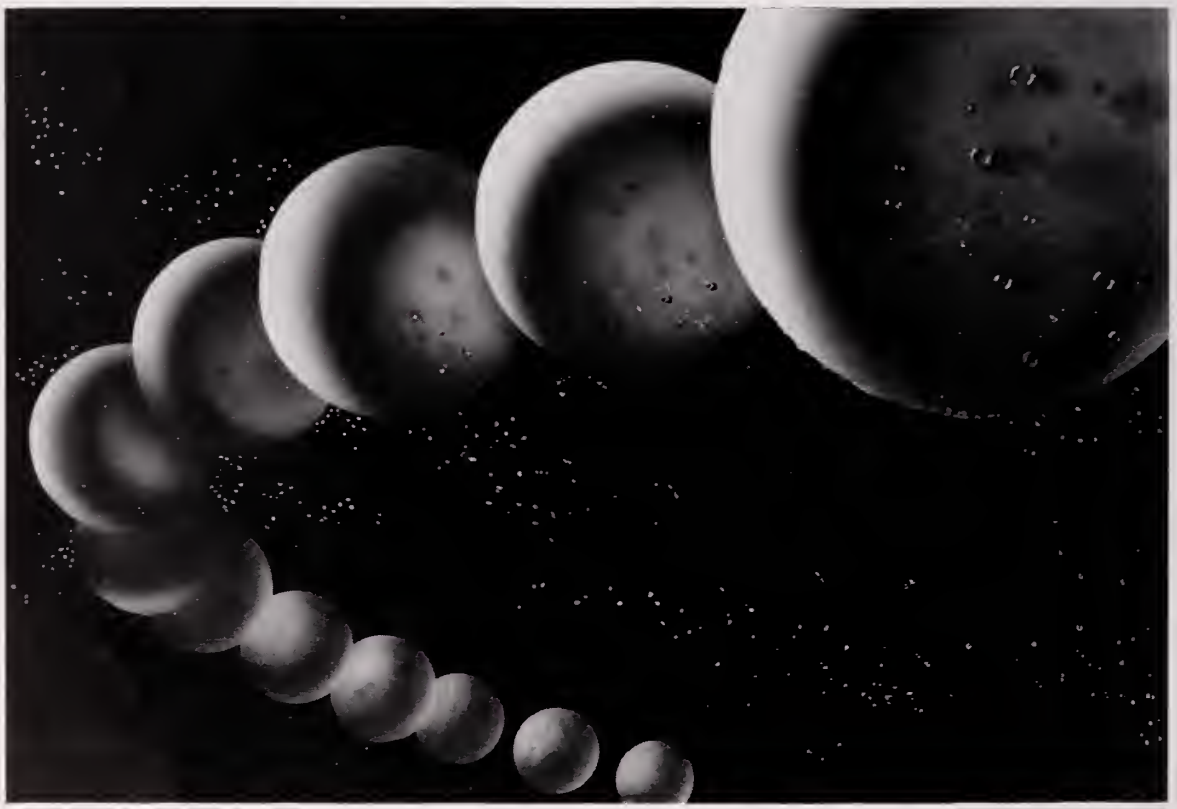
92962 PARKE, DAVIS & COMPANY, Detroit 32, Michigan

Many moons from now...

. . . and all the months in between . . . we will be here, ready to act as your executor — trained, responsible, helpful. The administration of your estate is our business . . . our responsibility. As your executor and trustee, we assure the permanence that is necessary to dispose of your property as you have specified.

We invite you to come in and see us at your convenience.

RHODE ISLAND
HOSPITAL TRUST COMPANY
Member F D I C



RHODE ISLAND
HOSPITAL TRUST
COMPANY
New England's Oldest Trust Company

OFFICES IN PROVIDENCE • CRANSTON • EAST PROVIDENCE • BRISTOL • EAST GREENWICH • NEWPORT • PAWTUCKET • WAKEFIELD • WOONSOCKET • WARWICK

The RHODE ISLAND MEDICAL JOURNAL

Editorial and Business Office: 106 Francis Street, Providence, R. I.

Editor-in-Chief: SEEBERT J. GOLDOWSKY, M.D.

Managing Editor: JOHN E. FARRELL, SC.D.

Senior Editors

ALEX M. BURGESS, SR., M.D. HENRI E. GAUTHIER, M.D.

Advisory Board

(in addition to editors listed above)

JOHN A. DILLON, M.D. JOHN F. W. GILMAN, M.D. ROBERT V. LEWIS, M.D.
PETER L. MATHIEU, M.D. JOSÉ M. RAMOS, M.D. ROBERT W. RIEMER, M.D.
JACK SAVRAN, M.D. LESTER L. VARGAS, M.D.

Owned and Published Monthly by
THE RHODE ISLAND MEDICAL SOCIETY
Second-class postage paid at Providence, Rhode Island
Copyright, 1962, the Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island
Single copies, 25 cents . . . Subscription, $2.00 per year.

Volume XLV, No. 11 November, 1962

TABLE OF CONTENTS

PAGE

TWO-TEAM COLON TRANSPLANT AND ESOPHAGECTOMY,
J. John Yashar, M.D., AND *Stephen J. Hoye,* M.D. ... 557

THE MANAGEMENT OF COMMON THYROID PROBLEMS,
Herbert A. Selenkow, M.D. ... 564

INJURIES DUE TO ILL-FITTING PROTECTIVE ATHLETIC EQUIPMENT, *Allan J. Ryan,* M.D. ... 568

EDITORIALS

Hospital Accreditation ... 571

End of an Era? ... 572

Peace Gesture? ... 572

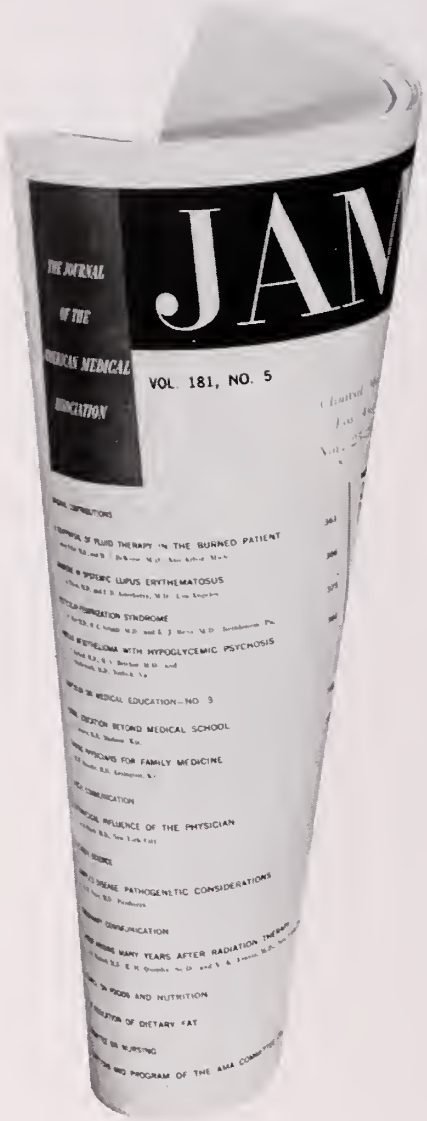
DEPARTMENTS

The Washington Scene ... 548

House of Delegates, R. I. Medical Society, Report of September Meeting ... 574

On the Medical Library Bookshelves ... 590

Book Reviews ... 596





Because you are aware of the AMA statement on fat in the diet...

"Increasing the ratio of poly-unsaturated fat to saturated fat in the diet is the preferred method for treating the 'usual' hypercholesteremia."

From the Aug. 4, 1962 issue of The Journal of the American Medical Association.

Of all leading salad and cooking oils Safflower Oil has the highest ratio of poly-unsaturated fat to saturated fat. Safflower Oil is higher in recommended poly-unsaturates—lower in saturated fat than any other readily available oil or shortening.

When an adjustment in dietary ratio of saturated fat is indicated, Saff-o-life

you should be aware of this new, poly-unsaturated oil for cooking

Safflower Oil makes the substitution easy, appetizing, inexpensive.

Physicians who wish recipes using Saff-o-life Safflower Oil are invited to write directly to: Professional Services Director, General Mills, Inc., Department 120, 9200 Wayzata Blvd., Minneapolis 26, Minnesota.

RATIO OF LINOLEATES* TO SATURATES *poly-unsaturated fats

SAFFLOWER OIL	9.0 to 1.0
CORN OIL	5.3 to 1.0
SOYBEAN OIL	3.5 to 1.0
COTTONSEED OIL	2.0 to 1.0
PEANUT OIL	1.6 to 1.0

A product of General Mills—Your assurance of quality and purity.



who coughed?

HYCOMINE® SYRUP for COUGHS

provides fast and long-lasting cough control

relieves cough in 15-20 minutes • lasts 6 hours or longer • promotes expectoration and decongestion of air passages • rarely constipates • agreeably cherry-flavored

Each teaspoonful (5 cc.) of HYCOMINE Syrup contains:

Hycodan®	6.5 mg.
Dihydrocodeinone Bitartrate (Warning: May be habit-forming)	5 mg.
Homatropine Methylbromide	1.5 mg.
Pyrilamine Maleate	12.5 mg.
Phenylephrine Hydrochloride	10 mg.
Ammonium Chloride	60 mg.
Sodium Citrate	85 mg.

Average adult dose: One teaspoonful after meals and at bedtime. May be habit-forming. On oral prescription where state laws permit. U.S. Pat. 2,630,400.

Literature on request

Endo®

ENDO LABORATORIES
Richmond Hill 18, New York



Welcome to another year of Lederle Symposia

Recognizing that the exchange of ideas is fundamental to medical progress, Lederle continues its Symposium program with the 11th year of scheduled meetings. Through these Symposia, sponsored by medical organizations with our cooperation, over 55,000 physicians have had the opportunity to hear and question authorities on important advances in clinical medicine and surgery. You have a standing invitation to attend any of these Symposia with your wife for whom a special program is planned.

SANTA BARBARA, CALIFORNIA
Saturday, November 3, 1962
Santa Barbara Biltmore Hotel

INDIANAPOLIS, INDIANA
Wednesday, November 7, 1962
The Marott Hotel

ANAHEIM, CALIFORNIA
Sunday, November 11, 1962
The Disneyland Hotel

KNOXVILLE, TENNESSEE
Thursday, November 15, 1962
Hotel Andrew Johnson

PHOENIX, ARIZONA
November 18, 1962
Westward Ho Hotel

NEW CITY, NEW YORK
Wednesday, November 28, 1962
Dellwood Country Club

LOS ANGELES, CALIFORNIA
November 29, 1962
Ambassador Hotel

GRAND RAPIDS, MICHIGAN
Saturday, December 1, 1962
Pantlind Hotel

NORFOLK, VIRGINIA
December 6, 1962
Golden Triangle Motor Hotel

DENVER, COLORADO
Sunday, January 13, 1963
The Cosmopolitan Hotel

FORT SMITH, ARKANSAS
Tuesday, January 15, 1963
The Holiday Inn

PORTLAND, OREGON
Thursday, January 31, 1963
The Sheraton-Portland Hotel

ANCHORAGE, ALASKA
Saturday, February 23, 1963
The Anchorage Westward Hotel

DETROIT, MICHIGAN
Wednesday, February 27, 1963
The Sheraton-Cadillac Hotel

WILMINGTON, DELAWARE
Saturday, March 9, 1963
Delaware Academy of Medicine

HUNTSVILLE, ALABAMA
Thursday, March 14, 1963
The Russel Erskine Hotel

FARGO, NORTH DAKOTA
Saturday, March 16, 1963
The Frederick Martin Hotel
(Moorhead, Minn.)

BELLINGHAM, WASHINGTON
Saturday, March 23, 1963
The Hotel Leopold

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.

asthma attack averted
. . . in minutes

patient protected
. . . for hours





Nephenalin®

(the dual-action anti-asthmatic tablet)

. . . works with nebulizer speed—provides four-hour protection

One NEPHENALIN tablet provides: *air in a hurry*—through sublingual isoproterenol HCl, 10 mg. *air for hours*—through theophylline, 2 gr.; ephedrine, 3/8 gr.; phenobarbital, 1/8 gr.

Dosage: Hold one NEPHENALIN tablet under the tongue for five minutes to abort the asthmatic attack promptly. Then swallow the tablet core for four full hours' protection against further attack. Only one tablet should be taken every four hours. No more than five tablets in 24 hours.

Supplied: Bottles of 50 tablets. For children: NEPHENALIN Pediatric, bottles of 50 tablets.

Caution: Do not administer NEPHENALIN with epinephrine. The two medications may be alternated at 4-hour intervals. NEPHENALIN should be administered with caution to patients with hyperthyroidism, acute coronary disease, cardiac asthma, limited cardiac reserve, acute myocardial damage, and to those hypersensitive to sympathomimetic amines. Phenobarbital may be habit forming. THOS. LEEMING & CO., INC., New York 17, N.Y.

THE WASHINGTON SCENE

A Summary Report Prepared by the Washington Office of the American Medical Association

INFLUENCED STRONGLY by the thalidomide incident, Congress approved legislation giving the Food and Drug Administration more control over the prescription drug industry.

The Kennedy Administration and Sen. Estes Kefauver (D., Tenn.), chief sponsor of ethical drug legislation, successfully exploited the thalidomide incident after prospects of passage of a strong drug bill waned.

However, they were unable to get all they wanted in the legislation even with the impact on Congress of the widespread publicity about the clinical testing of thalidomide in this country coupled with reports from Europe of births of malformed children by women who had taken the drug during pregnancy.

One administration proposal rejected by Congress would have given the secretary of Health, Education and Welfare authority to require physicians to report directly to him on their clinical tests with new drugs.

The new law empowers the FDA to require "subtantial evidence" of the efficacy, as well as safety, of new drugs before licensing them for marketing. The A.M.A. had warned Congress that this might lead to a test of relative efficacy which could result in potentially-helpful drugs being barred from sale. The A.M.A. contended that the old FDA requirement that a drug live up to its label claims was a sufficient test of effectiveness.

The Pharmaceutical Manufacturers Association also warned that drug research might slow down as a result of the new law.

"Some provisions of the new law may not be helpful to the public," the PMA said. "In fact, unless there is the wisest administration of the law harm can be done. For example, medical research may slow down and the costs of medications may increase."

Physicians will be required to get the consent of the patient, or a close relative, for treatment with experimental drugs except in instances where the physician feels that it would not be feasible or would be contrary to his professional judgment. Consent already is a part of the code of ethics of the American Medical Association.

Some other major provisions of the new law:

— Authorize the FDA to swiftly suspend any drug which it suspects is dangerous.

— Require that the generic name of a drug be printed on the label in type half as large as that for the trade name.

— Extends the time during which FDA may review a new drug application before it must be approved or disapproved.

— Authorizes the HEW secretary to establish generic names for new drugs.

— Authorizes the HEW secretary to prevent testing of drugs on humans if he determines there has not been sufficient preclinical testing.

— Require batch certification of all antibiotics.

* * *

Congress passed a bill authorizing a $36 million three-year program for federal aid for intensive vaccination programs against polio, diphtheria, whooping cough and tetanus.

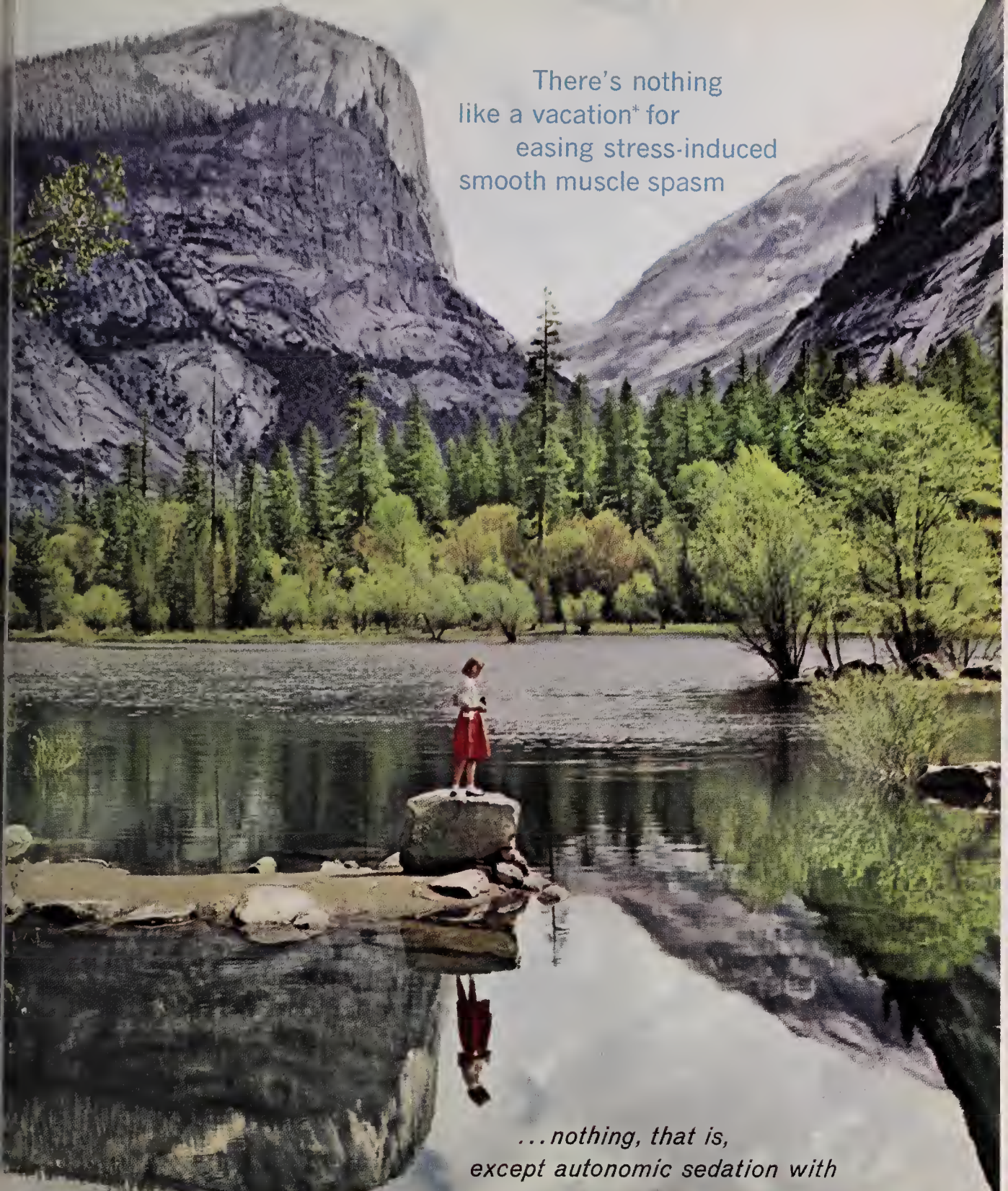
The vaccination campaigns are to be aimed primarily at children less than five years old. The U.S. surgeon general was given broad authority in deciding the amount and terms of federal grants under the program.

Grants will be made to states or, when approved by state officials, to cities or other local governmental units.

Also on the immunization front, a Special Advisory Committee twice recommended to the Public Health Service that Type III oral polio vaccinations be continued for preschool and school age children but not for adults for the time being.

The Public Health Service accepted the recommendation and urged that communities proceed with planned mass vaccination campaigns using Type III for children. But some communities decided to hold up their mass immunization programs at least temporarily or to suspend Type III doses for children, as well as adults.

The Advisory Committee first made its oral polio vaccine recommendation at an emergency meeting on September 15. The meeting was called after Canada suspended use of oral polio vaccine. The Health Ministry action in Canada, where all three types of the oral vaccine had been given in one dose, was prompted by the occurrence of a few cases of Type III polio. The three types of vaccine are given in separate doses in this country.



There's nothing
like a vacation* for
easing stress-induced
smooth muscle spasm

...nothing, that is,
except autonomic sedation with

DONNATAL®

Natural belladonna alkaloids plus phenobarbital

*This one at Mirror Lake, Yosemite Park

Prescribed by more physicians
than any other antispasmodic

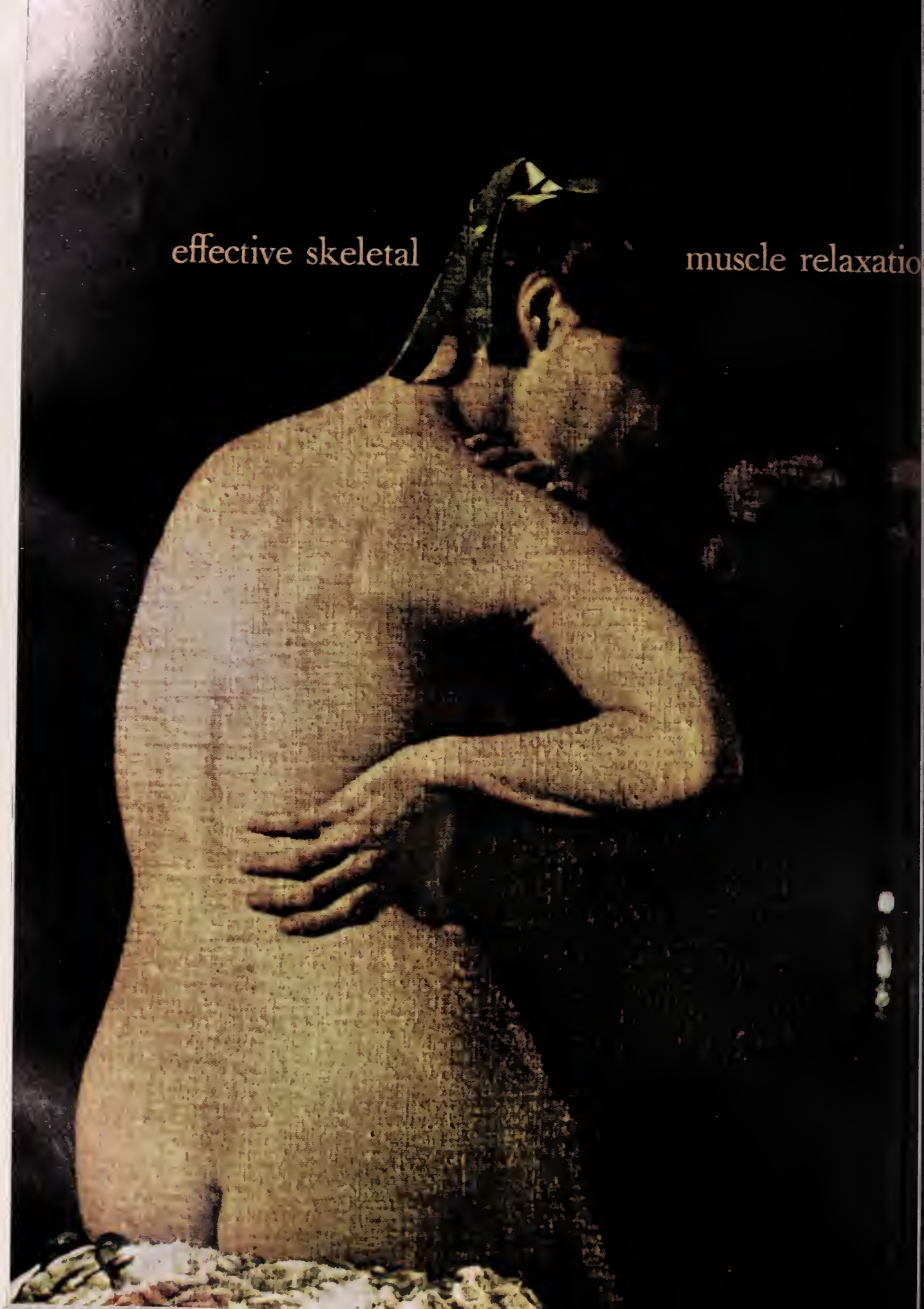
In each DONNATAL Tablet, Capsule or 5 cc. Elixir		In each DONNATAL Extentab
0.1037 mg.	hyoscyamine sulfate	0.3111 mg.
0.0194 mg.	atropine sulfate	0.0582 mg.
0.0065 mg.	hyoscine hydrobromide	0.0195 mg.
16.2 mg. (¼ gr.)	phenobarbital	(¾ gr.) 48.6 mg.

DONNATAL tablets • capsules • elixir
— for an easily adjusted t.i.d. or q.i.d. dosage regimen.

DONNATAL EXTENTABS®
— for day-long or night-long benefits on a single dose.

Robins

A. H. ROBINS CO., INC. • Richmond, Virginia


effective skeletal
muscle relaxatio

as each patient may require

—**for dramatic promptness:** ROBAXIN INJECTABLE usually provides relaxation of painful spasm *in minutes.* Clinicians have reported that it is "effective in producing immediate relaxation,"[7] and brings about "dramatic relief of pain and spasm" within 15 to 20 minutes.[3]

In each 10-cc ampul Methocarbamol (Robins) 1.0 Gm.

—**for prolonged use with safety:** ROBAXIN TABLETS safely maintain relief of spasm *without drowsiness.* "The effect does not wax and wane."[4] Continued use shows "no deleterious effect on normal muscle tone."[6]

In each white, scored ROBAXIN tablet Methocarbamol (Robins) 500 mg.
In each scored, capsule-shaped ROBAXIN-750 tablet Methocarbamol (Robins) 750 mg.

ROBAXIN®

Robaxin is methocarbamol (Robins) U. S. Pat. No. 2770649

—**for concurrent analgesia:** ROBAXISAL TABLETS, combining ROBAXIN with aspirin, are useful in spasm-triggering states that are painful in themselves, or when pain is prominently associated with muscle spasm.

In each pink-and-white laminated tablet Methocarbamol (Robins) 400 mg.
Acetylsalicylic acid (5 gr.) 325 mg.

—**for concurrent analgesia plus sedation:** ROBAXISAL-PH TABLETS, combining ROBAXIN with the sedative-reinforced analgesic PHENAPHEN®, are particularly helpful in giving comprehensive relief to patients in whom muscle spasm is accompanied by spasm-potentiating pain and apprehension.

In each green-and-white laminated tablet			
Methocarbamol (Robins)	400 mg.	Acetylsalicylic acid (1¼ gr.)	81 mg.
Phenacetin	97 mg.	Hyoscyamine sulfate	0.016 mg.
		Phenobarbital (⅛ gr.)	8.1 mg.

ROBAXISAL®

References: 1. Carpenter, E. B.: South. M. J. 51:627, 1958. 2. Hudgins, A. P.: Clin. Med. 8:243, 1961. 3. Lamphier, T. A.: J. Abdomin. Surg. 3:55, 1961. 4. Levine, I. M.: Med. Clin. N. America 45:1017, 1961. 5. Meyers, G. B., and Urbach, J. R.: Penna. M. J. 64:876, 1961. 6. Perchuk, E., Weinreb, M., and Aksu, A.: Angiology 12:102, 1961. 7. Poppen, J. L., and Flanagan, M. E.: J.A.M.A. 171:298, 1959. 8. Schaubel, H. J.: Orthopedics 1:274, 1959. 9. Steigmann, F.: Am. J. Nursing 61:49, 1961.

A. H. ROBINS COMPANY, INC. • Richmond, Virginia



control the two-headed dragon of *pain & spasm*

"HIGH THERAPEUTIC EFFECT"

A growing library of clinical reports on the use of ROBAXIN in painful skeletal muscle spasm continues to reaffirm its effectiveness, dependability, rapidity of action, and lack of significant side effects.

Some recent comments:

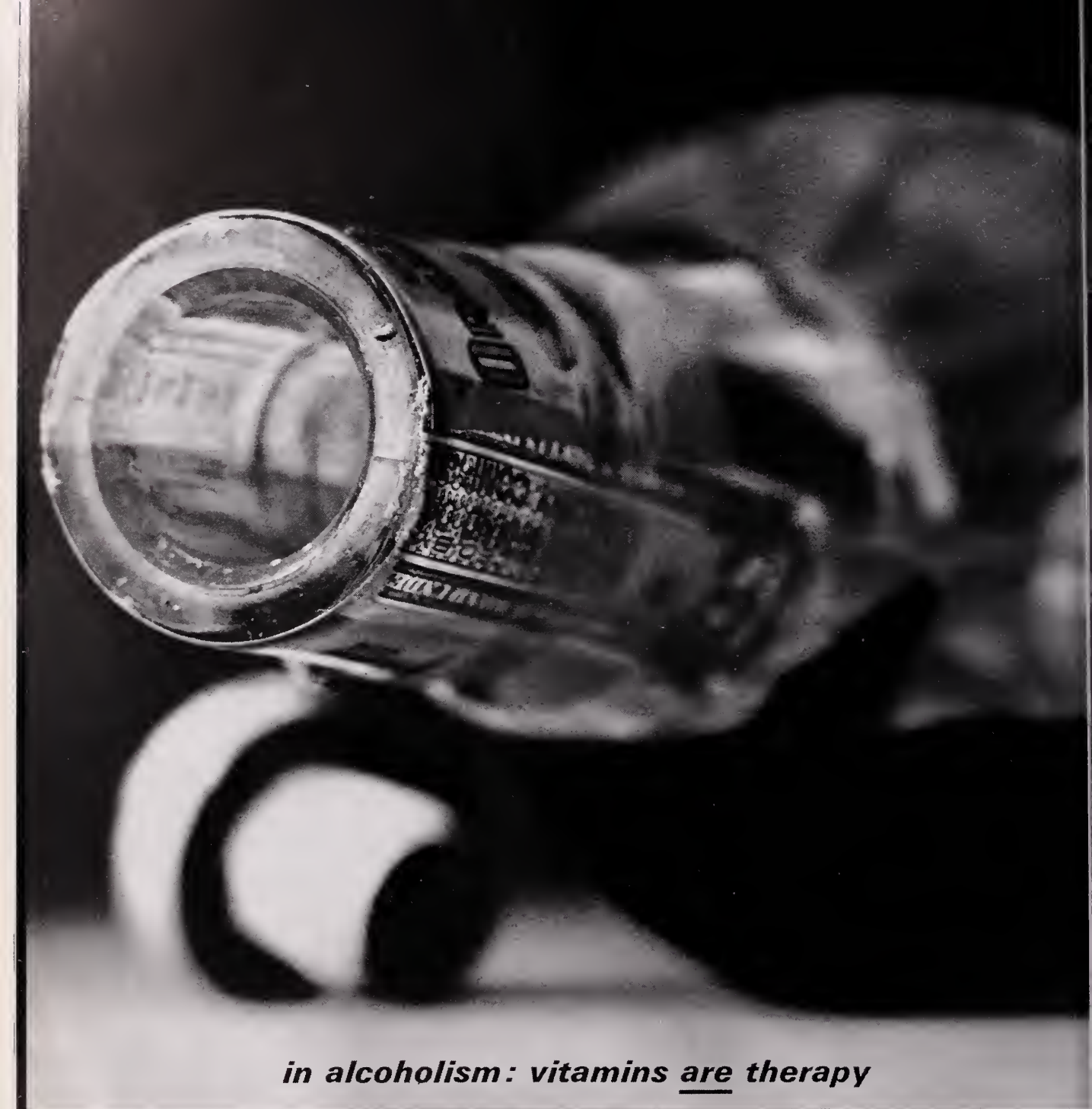
"...high therapeutic effect..."[5]

"...superior to other relaxants..."[9]

"...remarkably effective..."[2]

"...a high potential for prompt relief..."[8]

"...unusual freedom from toxicity..."[1]



in alcoholism: vitamins are therapy

A full "comeback" for the alcoholic is partly dependent on nutritional balance... aided by therapeutic allowances of B and C vitamins. Typically, the alcoholic patient is seriously undernourished...from long-standing dietary inadequacy, from depletion of basic reserves of water-soluble vitamins. Supplied in decorative "reminder" jars of 30 and 100.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

STRESSCAPS®

Stress Formula Vitamins Lederle

RELIEVE THE COLD SUPPRESS THE COUGH WITH NEW

'EMPRAZIL-C'

TABLETS

ANTITUSSIVE ▪ DECONGESTANT ▪ ANALGESIC

Each tablet contains:

Codeine Phosphate*	15 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Acetophenetidin	150 mg.
Aspirin (Acetylsalicylic Acid)	200 mg.
Caffeine	30 mg.

*Warning—may be habit forming.

Complete literature available on request.

Also available without codeine as

'EMPRAZIL'®

TABLETS



BURROUGHS WELLCOME & CO. (U.S.A.) INC., TUCKAHOE, N.Y.



WITH YOUR ENCOURAGEMENT

AND

DEXEDRINE®

brand of dextro amphetamine

SPANSULE®

brand of sustained release capsules

she's losing weight

'Dexedrine' *Spansule* capsules not only control appetite all day long, but at the same time encourage normal activity. This is particularly important because overweight patients are often inactive. In such patients 'Dexedrine' overcomes lethargy, helps renew their interest in doing things—not just eating.

PRESCRIBING INFORMATION

INDICATIONS AND DOSAGE: For the following indications, the recommended daily dosage is one or two 'Dexedrine' *Spansule* capsules, usually taken in the morning: control of appetite in weight reduction; depressive states; alcoholism. In narcolepsy, the recommended daily dosage is up to 50 mg. of 'Dexedrine' by 'Spansule' capsule on arising.

SIDE EFFECTS: Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

CAUTIONS: Should be used with caution in patients hypersensitive to sympathomimetic compounds; in cases of coronary or cardiovascular disease; and in the presence of severe hypertension.

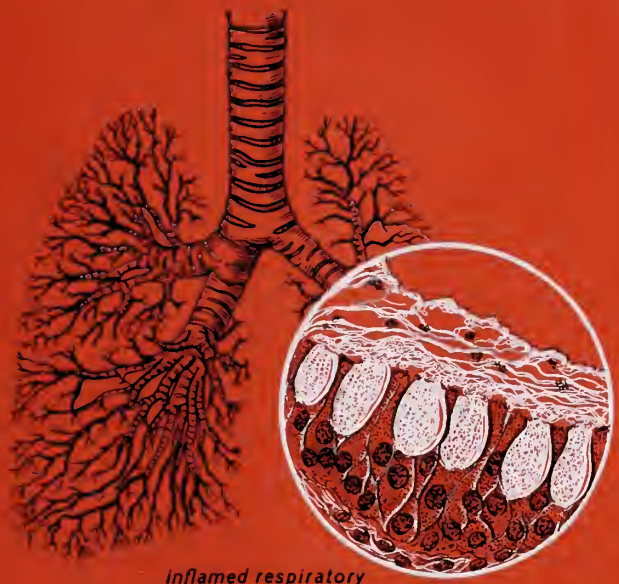
CONTRAINDICATIONS: Hyperexcitability; agitated pre-psychotic states.

SUPPLIED: 5 mg., 10 mg. and 15 mg., in bottles of 30. (Each capsule contains dextro amphetamine sulfate, 5 mg., 10 mg., or 15 mg.)

Prescribing information adopted January 1961.

Smith Kline & French SK&F *Laboratories*

INDICATION: *Acute respiratory inflammation*



inflamed respiratory tract mucosa

INDICATED: Chymoral®

cuts healing time in RESPIRATORY INFLAMMATION

By subduing the inflammatory reaction of respiratory tract tissues, Chymoral liquefies thickened bronchial secretions and affords easier expectoration of mucus plugs. In a series of 48 patients with bronchial asthma, 44 were afforded relief with Chymoral therapy that was judged "good to excellent."[1] In chronic obstructive emphysema, Chymoral has improved both vital capacity and the ability to expectorate without severe, racking cough effort.[2] And in sinusitis or rhinitis there is a definite reduction of inflammation and edema of the nasal and sinal mucosa, along with improved airflow.[2,3]

controls inflammation
curtails swelling, curbs pain

1. Taub, S. J.: Clin. Med. 7:2575, 1960. 2. Clinical Reports to the Medical Department, Armour Pharmaceutical Company, 1960. 3. Billow, B. W.; Cabodeville, A. M.; Stern, A.; Palm, A.; Robinson, M., and Paley, S.S.: Clinical Experiences with Oral Anti-inflammatory Enzyme for Intestinal Absorption. Southwestern Med. *41*:286, 1960.

CHYMORAL

Chymoral is an ORAL anti-inflammatory enzyme tablet (enteric coated). Each tablet provides enzymatic activity, equivalent to 50,000 Armour Units, supplied by a purified concentrate which has specific trypsin and chymotrypsin activity in a ratio of approximately six to one. ACTION: Reduces inflammation of all types; reduces and prevents edema except that of cardiac or renal origin; hastens absorption of blood and lymph extravasates; helps to liquefy thick tenacious mucous secretions; improves regional circulation; promotes healing; reduces pain. INDICATIONS: In respiratory conditions, inflammatory dermatoses, gynecologic conditions, obstetrics, surgical procedures, genitourinary disorders, dental and oral surgery, in conjunction with generally accepted measures of therapy. Antibiotics may be administered simultaneously. INCOMPATIBILITIES: None known. CONTRAINDICATIONS: None known. SIDE EFFECTS: Mild gastric upsets, rarely encountered. DOSAGE: Recommended initial dose is two tablets q.i.d.; one q.i.d. for maintenance. SUPPLIED: Bottles of 48 and 250 tablets. • For elaboration of this information consult the package insert.

Issue: Rev. Nov. 1961

ARMOUR PHARMACEUTICAL COMPANY KANKAKEE, ILLINOIS *Originators of Listica®*

CHYMORAL *ORAL systemic anti-inflammatory enzyme tablet*

"The first prescription I ever wrote was for 'Empirin' with Codeine...



and it is still my stand-by for pain relief today."

PICTURE THE YOUNG DOCTOR with his first private patient, about thirty-five years ago. This is the moment, after years of study and guidance in classroom and at hospital bedside, when he assumes the full weight of responsibility for the well-being of his patient. He makes his diagnosis. The patient is in considerable pain, and his first concern is to relieve this discomfort. He writes a prescription for a new analgesic, a convenient drug combination that he believes will be of help. This patient (and many others to follow) finds gratifying relief, and the physician continues to rely upon this medication as the years go by.

Could this have been you in the 1920's? That was when 'Empirin' Compound with Codeine first came into general use (although plain 'Empirin' Compound has been well-known since the influenza epidemic of 1918). Satisfaction through the years has prompted doctors everywhere to depend on 'Empirin' with Codeine for relief of most all degrees of pain. For with this well-tolerated, reliable analgesic combination you can be sure of results, and feel secure in the fact that the liability of addiction is negligible.

Please accept our thanks for continuing to place your trust in a product that has been used more widely in medicine each year for the past four decades.

'EMPIRIN' COMPOUND with CODEINE PHOSPHATE*

Acetophenetidin, gr. 2½
Acetylsalicylic Acid, gr. 3½
Caffeine, gr. ½

Remember there are now four strengths available...

*Warning—May be habit-forming.
Subject to Federal Narcotic Regulations.

No. 1 — gr. ⅛
No. 2 — gr. ¼
No. 3 — gr. ½
No. 4 — gr. 1

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

the first comprehensive regulator of female cyclic function

ENOVID®

(brond of norethynodrel with ethynylestrodiol 3-methyl ether)



Simple adjustments of the dosage schedule with this versatile therapeutic agent enable the physician to: *control dysfunctional uterine bleeding, regulate an abnormal menstrual cycle, enhance or suspend fertility, advance or postpone the menses, correct endometriosis often without surgery.*

The Basic Action. ENOVID (1) induces and maintains a pseudodecidual endometrium, preventing uterine bleeding, (2) inhibits pituitary gonadotropin, preventing ovulation.

When ENOVID is withdrawn, bleeding occurs in about three days and usually resembles a normal menstrual period in duration and volume of flow.

Cyclic **ENOVID Therapy.** When ENOVID is prescribed for 20 days of each cycle, commencing on day 5, the menstrual cycle will adjust to about 28 days regardless of menstrual timing prior to ENOVID therapy. A few cycles of therapy will frequently restore a normal pattern to women with irregularities as menorrhagia, metrorrhagia or secondary amenorrhea. Since ovulation is inhibited, ENOVID may be prescribed *cyclically* over prolonged periods to suspend fertility. During ENOVID therapy the ovary remains in a state of physiologic rest. After discontinuance of the drug the normal ovulatory pattern returns. Indeed, subsequent pregnancy appears to be enhanced through a probable "rebound" phenomenon. Thus, *cyclic* ENOVID administration has been successful in treating endocrine infertility.

Continuous **ENOVID Therapy.** When ENOVID is given on a *continuous* dosage basis, menstruation as well as ovulation is completely suspended. In endometriosis, *continuous* ENOVID therapy produces a pseudodecidual reaction with subsequent absorption of aberrant endometrial tissue. This often eliminates the need for radical surgery. When surgery is indicated, ENOVID is an effective adjunct preoperatively, as well as postoperatively, to prevent recurrence.

Continuous administration of ENOVID is also utilized in habitual abortion, providing balanced hormonal support of the endometrium and permitting continuation of pregnancy.

Emergency **ENOVID Therapy.** In high doses, ENOVID has a prompt hemostatic effect and will usually control severe dysfunctional uterine bleeding within 6 to 24 hours. Prompt, high-dosage administration of ENOVID is also a rational recourse in threatened abortion.

A Note on Safety. The effects of ENOVID have been studied in more than 3,500 women during more than 49,500 menstrual cycles, representing 3,800 woman-years of experience. ENOVID has been administered *cyclically* to the same patients for as long as five and one-half years for ovulation inhibition without serious complication. For the present, however, ENOVID is not recommended for more than two years, although it is expected that this period will be lengthened as experience continues to accumulate. There has been no impairment of subsequent fertility and no effect on children born to women who conceived after discontinuing ENOVID therapy.

The basic dosage of ENOVID is 5 mg. daily in *cyclic* therapy, beginning on day 5 through day 24 (20 daily doses). Higher doses may be used to prevent or to control occasional "spotting" or breakthrough bleeding during ENOVID therapy or for rapid effect in the emergency treatment of dysfunctional uterine bleeding or threatened abortion.

ENOVID is available in tablets of 5 mg. and of 10 mg. Available on request: literature and references covering more than six years of intensive clinical study.

SEARLE

Research in the Service of Medicine

G. D. Searle & Co., P.O. Box 5110, Chicago 80, Ill.

The RHODE ISLAND MEDICAL JOURNAL

VOL. XLV NOVEMBER, 1962 NO. 11

TWO-TEAM COLON TRANSPLANT AND ESOPHAGECTOMY*

J. JOHN YASHAR, M.D., AND STEPHEN J. HOYE, M.D.

The Authors, *J. John Yashar, M.D., Associate Surgeon, Active Staff, Miriam Hospital; Thoracic and Cardiovascular Surgeon, Active Staff, Roger Williams General Hospital; Assistant Surgeon, Active Staff, Pawtucket Memorial and St. Joseph's hospitals.*
Stephen J. Hoye, M.D., Assistant Surgeon, Pawtucket Memorial, Miriam, Our Lady of Fatima, and Roger Williams General hospitals; Instructor in Surgery, Harvard Medical School.

INTRODUCTION

ALTHOUGH ESOPHAGECTOMY is not difficult technically in experienced hands, the problem of esophageal replacement has intrigued surgeons for many years. Since the first successful esophagectomy in 1913 by Torek many substitutes such as skin, stomach, jejunum, and finally large bowel have been used.[1,2,3,4,12] Every method of transplant thus far utilized has at least one major disadvantage, and usually several minor ones as well. An ideal substitute for the esophagus should be resistant to peptic juices so that ulceration, stricture, and bleeding do not occur. It should be a satisfactory conduit for food without encroaching on pulmonary tissue. Its transplantation must be technically feasible, and there should be an adequate blood supply to both anastomoses.

The stomach, because it is readily available, has commonly been used for intrathoracic anastomoses even as high as the pharynx. In general, however, the higher above the aortic arch the anastomosis is made, the greater are the technical and functional problems and the greater the morbidity and mortality. Furthermore, peptic esophagitis and ulceration of esophageal mucosa are frequent postoperative complications.[5] In anastomosis above the aortic arch, regurgitation and aspiration may be troublesome and particularly in infants gastric dilatation may seriously embarrass respiration. Jejunal loops, first proposed by Wulkenstein in 1904 and first used by Roux in France in 1907, are now commonly transplanted intrathoracically, although a few surgeons still transplant them subcutaneously. One of the major problems is related to the length of the loop that can be mobilized without impairing the blood supply. Nerosis is reported to occur in one quarter to one half of the cases. If the distal segment is anastomosed to the stomach, the incidence of peptic ulceration is very high. If the stomach is bypassed (Roux-Y method), nutrition seems to be impaired,[6] and the bypassed gastroduodenal segment is prone to ulceration.

The colon was used first as a subcutaneous transplant to replace the skin tubes which were fashioned by the Toreck multi-stage procedure. Since World War II, there has been a revival of this method in western Europe. Recently in this country, small series of intrathoracic transplantation for benign and malignant diseases have appeared.[10,11,12] A long and adequate segment from cecum to the splenic flexure with unquestioned viability can be obtained easily and quickly. Infection, which was a major problem prior to the advent of antibiotics, can now be minimized by their use to sterilize the colon. The relatively high resistance of the colon to peptic digestion[4-7] makes a cologastric anastomosis more feasible.

During the past year, we have had the opportunity of using the right colon as a replacement for all or part of the esophagus in four cases with an excellent result both early and late. A presentation of our experience with a consideration of indications and technique will support our view that intrathoratic transplantation of the colon to bridge gaps in esophageal continuity is worthy of wider consideration.

Indications for Esophagectomy and Colon Transplant

In the pediatric age group:

1. esophageal atresia with insufficient esophageal substance for primary anastomoses
2. chemical strictures
3. tracheo-esophageal fistula associated with atresia

continued on next page

*From the Thoracic-Surgical Departments of The Miriam Hospital and the Roger Williams General Hospital, Providence, Rhode Island.

4. peptic esophagitis of a severe degree with stricture
5. bleeding esophageal varices after the failure of shunt therapy.

In the adult:

1. localized carcinoma of the esophagus amenable to curative resection
2. peptic esophagitis with severe and elongated stricture
3. acquired tracheo-esophageal fistula.

Technique

Because of the obstructing nature of the pathology (carcinoma or stricture), the majority of patients subjected to this procedure are suffering from malnutrition, hypovolemia, and electrolyte imbalance. Preoperative preparation consists of restoration of nutritional status, and electrolytes either by feedings through a small polyethylene tube passed into the stomach at the time of esophagoscopy or by tube gastrostomy. Preparation of the large bowel is similar to that in other large bowel surgery, consisting of a low residue diet for two or three days prior to operation and clear fluids the day before surgery. Fleet Phospho-soda® ½ oz. twice daily, Neomycin® 4 gm. daily, and Sulfathalidine® 8 gm. daily are administered to patients for three or four days prior to surgery. The day before operation a cleansing enema is given until the return is clear.

A two-team approach has been used with the patient placed in a right or left semilateral position. For lesions of the terminal three or four centimeters of the thoracic esophagus and esophagogastric junction, left thoracotomy is performed. For higher lesions which require extensive resection of the thoracic esophagus, the right chest is approached through a right thoracotomy incision. After careful evaluation of the lesion and the decision as to resectability has been made, the thoracic team proceeds with esophagectomy. The azygous vein is divided and the entire thoracic esophagus with surrounding fascia and right mediastinal pleura is removed. The esophagus is divided at the cardia, the distal end is sutured with two layers of catgut and silk sutures, and is dropped back into the abdomen.

After the feasibility of esophagectomy has been ascertained, the abdominal team proceeds with the abdominal part of the operation, so that the two teams are working simultaneously. Through a right paramedian incision the complete mobilization of the cecum, ascending and the proximal half of the transverse colon is carried out. The ileocolic, right colic, and middle colic arteries are identified, and the right colic and ileocolic vessels are occluded for a period of seven to ten minutes, and the adequacy of blood supply through the middle colic artery is observed. During this waiting period the appendix

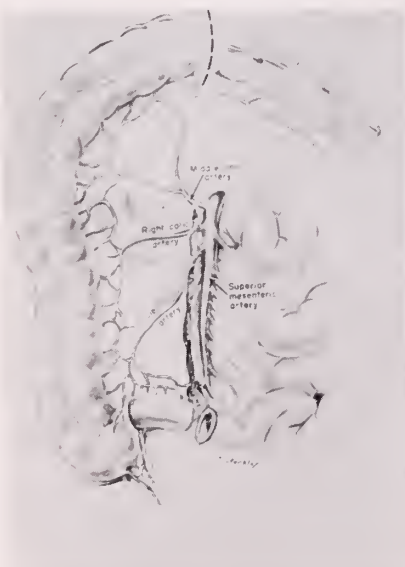


FIGURE 1

Complete mobilization of right colon. The ileocolic and right colic vessels are divided at their respective origin (after Groves, reproduced with permission of the author).



FIGURE 2

The cecum is brought into the chest through the lesser sac and posterior to the antrum of stomach (after Groves, reproduced with permission of the author).

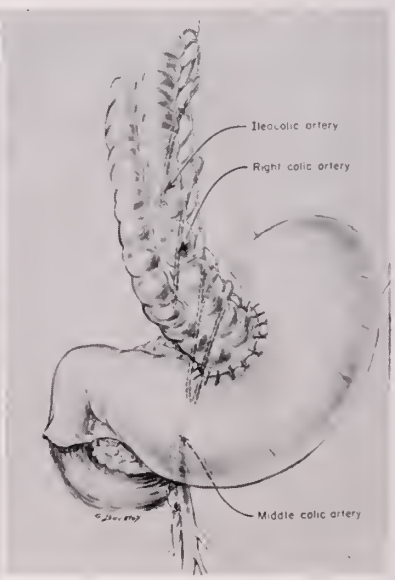


FIGURE 3

The distal end of the transplanted colon is sutured to the anterior wall of stomach (after Groves, reproduced with permission of the author).

is removed, and the stump is inverted. The ileum is divided one to two inches from the ileo-cecal valve and the distal stump is closed and inverted in two layers, leaving the silk sutures long enough for traction of the right colon into the chest. If the circulation of the colon appears to be adequate, the right colic and ileo-colic arteries and veins are divided at their origin and the mesenteries are divided (Figure 1).

The esophageal hiatus is enlarged by dividing the left portion of the right crus of the diaphragm through the abdominal incision. This opening should be large enough to admit the transplanted colon without any difficulty. The cecum is then brought through the lesser sac posterior to the antrum of the stomach and through the enlarged hiatus into the right chest (Figure 2). This maneuver gives additional length to the transplanted colon and lessens the theoretical hazard of vascular thrombosis due to gastrict dilatation. Special care must be exercised not to twist the bowel during the transference of the colon into the chest lest there be thrombosis of the vascular pedicle. The esophagus is then divided about three to four inches proximal to the lesion, usually at the apex of the right chest in mid-thoracic esophageal carcinoma. Esophagocecostomy is performed in three layers using interrupted 0000 silk sutures. It appears to be safer and more logical to use the taenia of the cecum as the site of anastomosis, because it has more strength and gives better support to the heavy transplanted colon. For further support the bowel then is sutured with a few interrupted silk sutures to the parietal pleura. After the appropriate length of the transplanted colon is determined, the transverse colon is divided at an appropriate site beyond the middle colic artery and anastomosed to the anterior wall of the stomach using a two-layer anastomosis (Figure 3). A Ramstedt pyloromyotomy or a pyloroplasty is performed for adequate drainage of the vagectomized stomach. Tube gastrotomy in the upper third of the stomach is performed, and the tube is brought out through a small incision just below the left costal margin. Normal continuity of the bowel is re-established between the cut end of the proximal ileum and distal end of the transverse colon in end to end fashion, and the mesentery of the bowel is closed (Figures 4 and 5). In children, where a long thin mesentery and a redundant transverse colon coexists with a relatively short thoracic esophagus, transverse colon alone is adequate for transplantation. Because of the weight of the transplanted colon and the lack of adhesions with the surrounding tissue for the first few days after surgery, the patient is kept in bed for three days in a flat or semisitting position, allowed to turn from

continued on next page

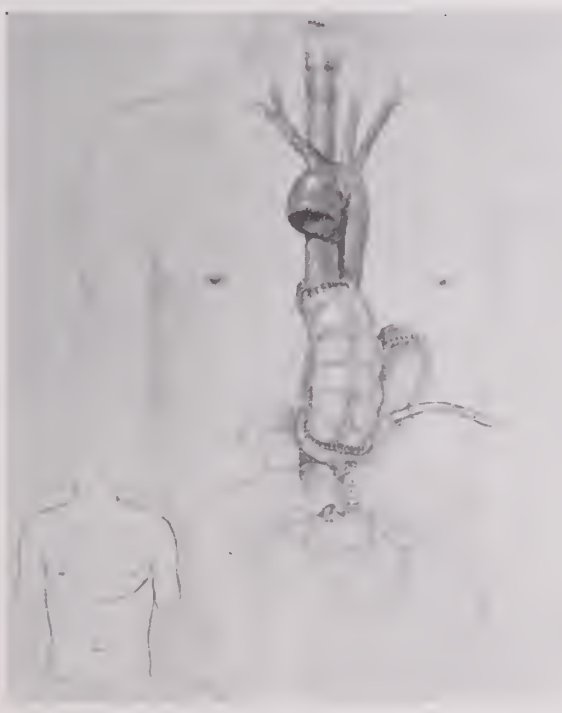


FIGURE 4

Diagrammatic sketch of completed operation for lesions of lower half of the esophagus (after Neville, reproduced with permission of the author).



FIGURE 5

Diagrammatic sketch of completed operation for lesions of upper half of the esophagus (after Neville, reproduced with permission of the author).

side to side, but not in a completely upright position. The gastrostomy tube is connected to suction until there is normal peristaltic activity. Oral feeding is withheld for six days and then is started with two ounces of fluid every hour, gradually increasing to a six-meal bland diet within the next six or seven days. Gastric residual is measured at the end of each day, usually about three or four hours after the last feeding. If the residual is more than 200 ml. the gastrostomy tube again is connected to suction overnight. Oral feeding is again resumed the next morning with the gastrostomy tube clamped. Usually the gastrostomy tube is removed on the tenth or twelfth postoperative day, and the patient is discharged a few days later.

Case Reports

Case 1. M.H. Miriam Hospital No. 90484. This two and a half-year-old-white male was admitted on March 22, 1961, because of dysphagia and inability to swallow anything but fluids for the past eight months. His mother stated that he had swallowed lye in August of 1960. He was immediately admitted to the hospital for treatment. In spite of corticosteroids and early treatment he developed stricture of the lower end of the esophagus. He had more than ten admissions to various hospitals in the city for frequent bougienage with no apparent improvement. On admission to The Miriam Hospital, in spite of a long history of stricture, he appeared to be well hydrated and weighed 30 pounds. He was unable to swallow anything except fluids. Physical examination was essentially unremarkable. Barium swallow X-ray studies revealed a stricture of the lower half of the thoracic esophagus with some dilatation proximally (Figure 6).

On March 27, 1961, through a left thoracotomy combined with a left paramedian incision the lower half of the esophagus just beyond the aortic arch was resected and was replaced by a transplanted segment of the transverse colon from the hepatic to the splenic flexure. The distal end of the transverse colon was sutured to the anterior surface of the stomach. Colocolostomy, pyloroplasty, and gastrostomy completed the procedure. His postoperative course was extremely smooth and uneventful. He was started on oral feeding seven days after surgery, the gastrostomy tube was removed a few days later, and he was discharged from the hospital on April 14, 1961, on a regular diet.

The first few months after operation, the patient

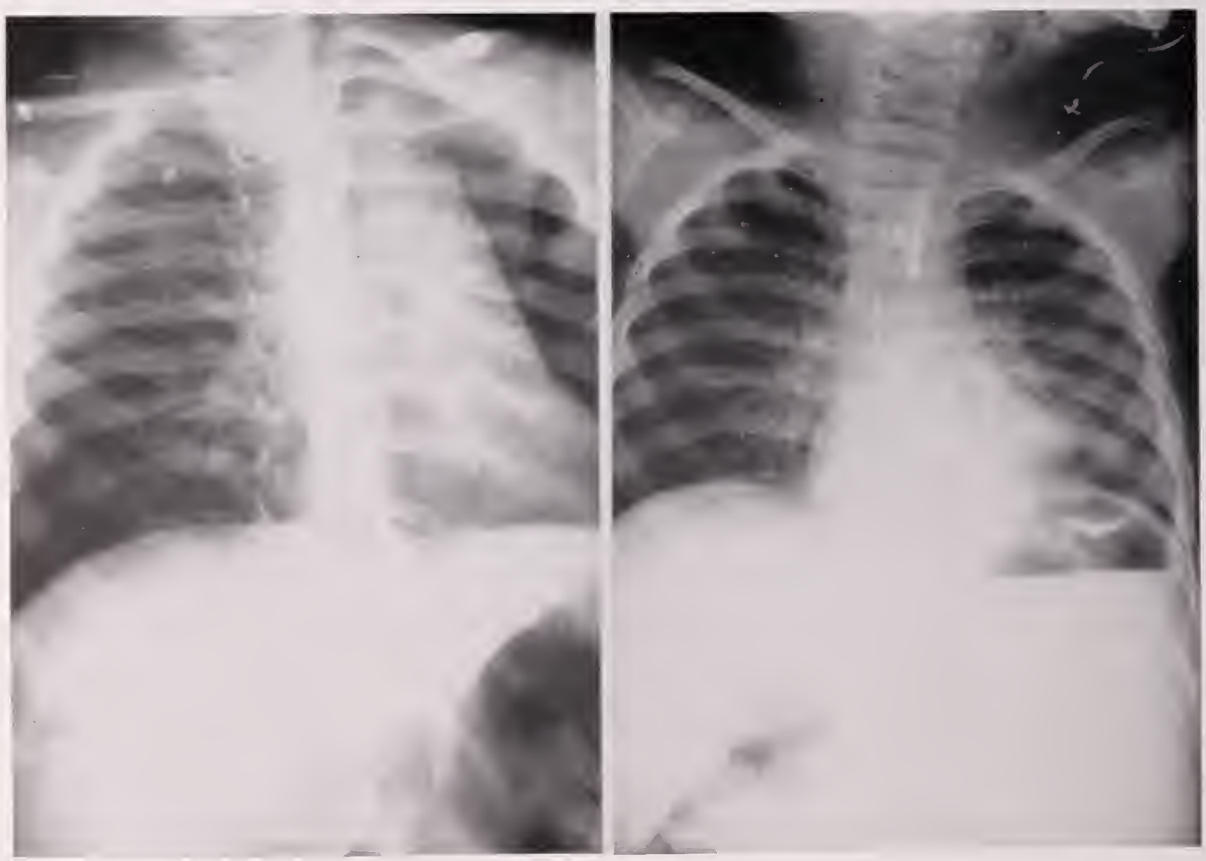


FIGURE 6

Case No. 1, on the left, preoperative barium swallow demonstrating stricture of lower half of the esophagus. On the right, fourteen days after esophagectomy and transverse colon transplant.

had difficulty in gaining weight and had frequent loose bowel movements. However, this problem gradually improved over the next few months. At present he has gained about 15 pounds of weight, has no difficulty in swallowing (Figure 6), and has a regular daily bowel movement.

Case 2. M.C. Roger Williams General Hospital No. 207667. This seventy-nine-year-old white Italian male was admitted with a three-and-a-half-month history of dysphagia and inability to swallow solid food, associated with recent retrosternal chest pain. Physical examination revealed an extremely well-preserved male for his stated age. Cardiovascular system was essentially normal with no murmurs. Barium swallow X-ray studies revealed partial obstruction of the mid-thoracic esophagus by an intraluminal mass. The proximal esophagus was slightly dilated. Esophagoscopy revealed highly undifferentiated squamous carcinoma of the esophagus about 25 cm. beyond the upper teeth.

On May 16, 1961, right thoracotomy was performed. A large mass of the mid-esophagus with extension to the carinal lymph nodes and mid-mediastinal lymph nodes was found. The entire thoracic esophagus was removed. The right colon was mobilized through a right paramedian incision and was introduced into the chest through the enlarged esophageal hiatus. Esophagocecostomy, cologastrostomy, pyloroplasty, gastrostomy, and ileocolostomy completed the procedure. His postoperative course was uneventful. He was given oral fluids seven days after surgery, and was advanced gradually to a house diet. He was discharged on his seventeenth postoperative day in satisfactory condition. Seven months following esophagectomy, he developed recurrent carcinoma at the site of esophago-colostomy. He gradually went downhill, and expired in February of 1962.

Case 3. A.B. Roger Williams General Hospital No. 209123. This seventy-three-year-old white male entered with a one-month history of inability to swallow solid food and a seven-pound weight loss. Physical examination was unremarkable. He was a well-developed, well-nourished man with a blood pressure of 150/90. Barium swallow revealed a filling defect of the mid-esophagus (Figure 7). Esophagoscopy revealed a lesion of the mid-esophagus about 32 cm. beyond the upper teeth. Pathological report of the biopsy revealed anaplastic squamous cell carcinoma of the esophagus.

On July 10, 1961, under endotracheal anesthesia the esophagus was explored through the right chest. A well localized carcinoma of the esophagus was found just below the carina with no evidence of involvement of the surrounding tissue. The entire thoracic esophagus was removed and was replaced by a transplanted right colon. The cecum was anastomosed at the apex of the right chest to the esophagus, and the distal part of the transverse colon to the anterior part of the mid-stomach. The continuity of the bowel was reconstructed by ileo-transverse colostomy, and pyloroplasty and gastrostomy were performed. The patient tolerated the procedure well, and his postoperative course was extremely smooth. He was discharged two weeks after surgery on a regular house diet. Since surgery he has gained 17 pounds of weight and is asymptomatic. Repeat gastrointestinal X-ray series eleven days after surgery revealed a satisfactorily functioning anastomosis with no evidence of recurrence (Figure 7).

Case 4. E.S. Miriam Hospital No. 92955. This fifty-nine-year-old white male was admitted with a two-month history of dysphagia, inability to swallow solid food, retrosternal discomfort, and 15 pounds of weight loss. Patient apparently had been in good health all his life, working as a truck driver for many years. Two months prior to admission, he noted difficulty in eating solid food which gradually became progressively worse and at the time of admission to the hospital he was able to swallow only fluids and strained food. Barium swallow X-ray studies which were carried out shortly before his admission to the hospital revealed carcinoma of the mid-esophagus with partial obstruction (Figure 8).

On August 9, 1961, under endotracheal anesthesia the esophagus was explored through the right chest, and a carcinoma of the mid-portion of the esophagus about 8 cm. in length was found with no evidence of direct involvement of the surrounding structures. A few lymph nodes around the lesion were found to be involved by tumor. The entire thoracic esophagus was mobilized and removed. The second team mobilized the cecum and ascending and transverse colon through a right paramedian incision. The cecum was delivered to the apex of the right chest and was anastomosed to the esophagus at the thoracic inlet without difficulty. The distal end of the transplanted transverse colon was anastomosed to the stomach; pyloroplasty, gastrostomy, appendectomy and ileocolostomy completed the operation.

His post operative course was smooth, the thoracotomy tube was removed a few days later. He was discharged from the hospital 18 days after surgery in satisfactory condition. At present, he is asymptomatic, has gained ten pounds of weight, and is working as a truck driver (Figure 8).

Discussion

General agreement is lacking as to the best method for treating carcinoma of the esophagus. Some surgeons have abandoned surgical treatment for carcinoma of the esophagus, but others continue

continued on next page

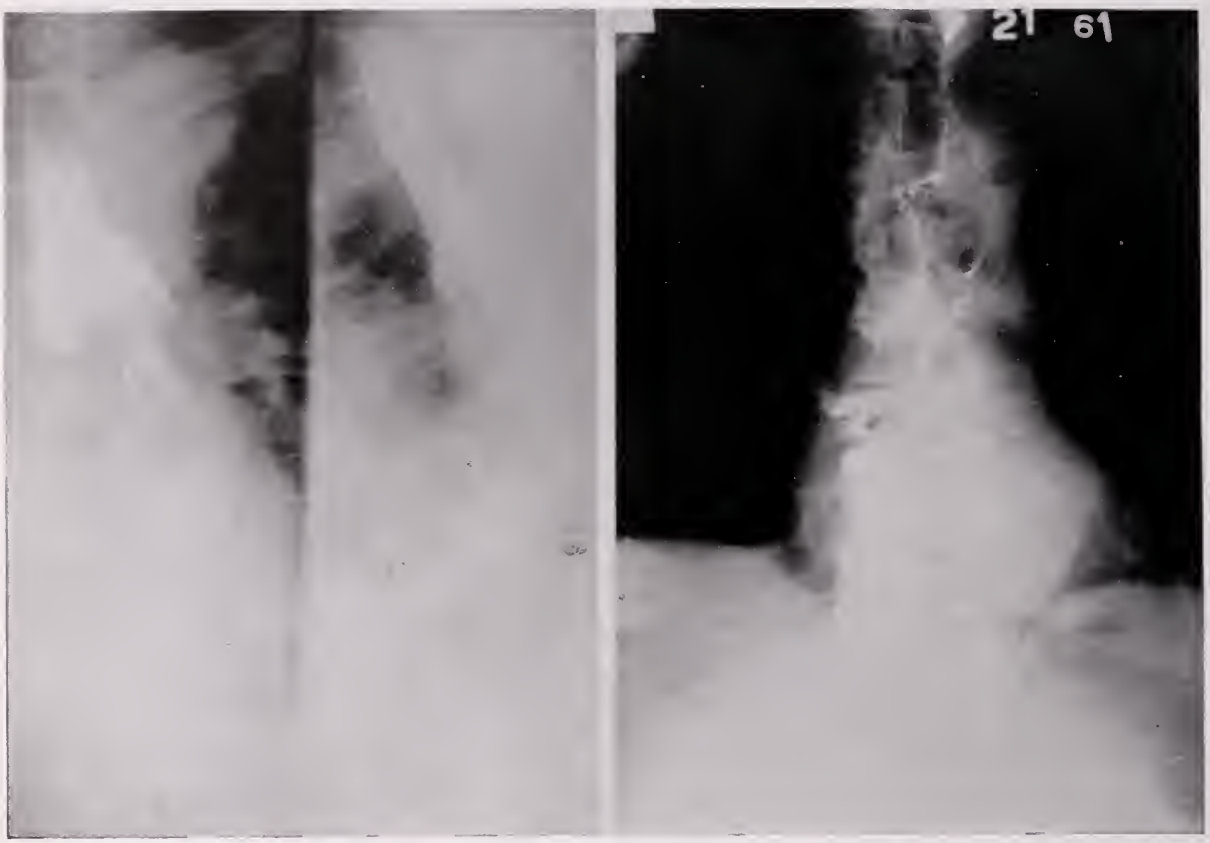


FIGURE 7

Case No. 3, on the left, preoperative esophagogram demonstrating carcinoma with almost complete obstruction of the mid-esophagus. On the right, eleven days after esophagectomy and colon transplant.

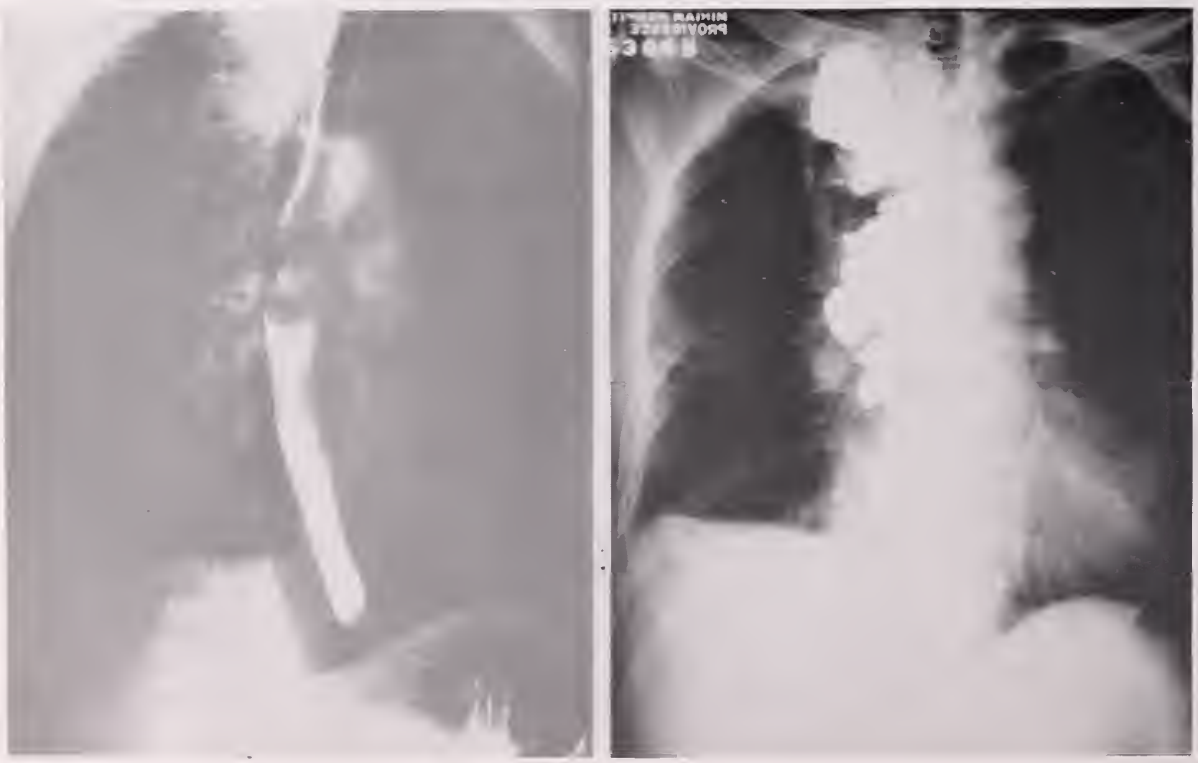


FIGURE 8

Case No. 4, on the left, esophagogram demonstrating carcinoma of the mid-esophagus. On the right, six months after esophagectomy and colon transplant.

to employ radical resection wherever possible. Supervoltage radiation therapy, bypass procedures to allow swallowing by transplanting loops of the jejunum or colon, and combined radiation therapy all have their supporters.[8]

Since one of the discouraging aspects of the surgical treatment of carcinoma of the esophagus is the extensive submucosal lymphatic involvement which is present beyond the gross confines of the tumor,[9] an effort toward more extensive resections is facilitated by adequate replacement. The satisfactory use of the right colon[10] has allowed this wider resection which may eventually be reflected in the survival statistics. In patients with carcinoma of the upper two thirds of the esophagus, a careful consideration for resection must be given to each case. Esophagectomy should be attempted if there is a reasonable chance for cure. In carcinoma of the lower one third of the esophagus, the stomach is a more reasonable substitute than the colon, because of its immediate proximity and ease of the required mobilization.

The two-team approach with resection and transplantation in one stage has been utilized in our cases in an effort to reduce the 40 per cent mortality reported in the literature for this procedure.[12] The great reduction in operative time, which is usually from three to four hours, compensates for the slight inconveniences due to the patient's position on the operating table.

The most serious postoperative complications, anastomotic leak and stricture, were avoided in this series by assiduous attention to the adequate vascularity of the transplanted colon. Moderate diarrhea and difficulty in gaining weight, which is due to loss of absorbing surface of large bowel, was present in one case, but was gradually overcome with minimal medical measures.

Conclusions

Restoration of esophageal continuity by colon transplant after resection for benign or malignant disease is a safe and practicable procedure. The two-team approach, where possible, contributes significantly to reducing operative time and trauma.

References

[1]Longino, L. A.; Wooley, M. M., and Gross, R. E.: Esophageal Replacement in Infants and Children with Use of a Segment of Colon. J.A.M.A. 171:1187, 1959

[2]Garlock, J. H.: Resection of the Thoracic Esophagus Above the Arch of the Aorta: Cervical Esophagogastrostomy. Surgery 24:1, 1948

[3]Yudin, S. S.: The Surgical Construction of Eighty Cases of Artificial Esophagus. Surg. Gyn. & Obs. 78:516, 1944

[4]Neville, W. E., and Clowes, G. H. A., Jr.: Reconstruction of the Esophagus with Segments of the Colon. J. Thoracic Surgery 35:2, 1958

[5]Ripley, H. R.; Olson, A. M., and Kirklin, J. W.: Esophagitis after Esophagogastric Anastomosis. Surgery 22:1, 1952

[6]Everson, T. C.: Effect of Esophagoduodenostomy and Esophagojejunostomy on Fecal Fat and Nitrogen Loss Following Total Gastrectomy. S. Forum p. 68, 1951

[7]Sirak, H. D.; Clatworthy, H. W., Jr., and Elliot, D. W.: An Evaluation of Jejunal and Colonic Transplants in Experimental Esophagitis. Surgery 35:399, 1954

[8]Ellis, F. H.: Treatment of Carcinoma of the Esophagus and Cardia. Proc. Staff Mtg. of Mayo Clinic 35:653

[9]Scanlon, E. F.; Morton, D. R.; Walker, J. M., and Watson, W. L.: The Case Against Segmental Resection for Esophageal Carcinoma. Surg. Gyn. & Obs. 101:290, 1955 son, W. L.: The Case Against Segmental Resection for

[10]Reynolds, J. T.; Gwynn, V. L.; Grove, W. J., and Javide, H.: Experience with the Use of the Right Colon to Replace the Esophagus. Am. J. of Surgery 101:39, 1961

[11]Beck, A. R.; Kreel, I., and Baronofsky, I. D.: Use of the Left Colon to Replace the Esophagus. Am. J. of Surgery 101:32, 1961

[12]Groves, L. K., and Turnbull, Jr., R. B.: Cleveland Clinic Quarterly 28:90, 1961

FOR RENT - - - IN WARWICK

2332 POST ROAD

First floor. 5½ rooms. Extra lavette. 2 front entrances. Good parking front and rear. Cellar facilities, Air conditioning available.

For more details contact:

GLENN PHARMACY

500 Pawtucket Ave., Pawtucket, R. I.

Phone: PA 3-2882

E. P. ANTHONY, INC.

Druggists

WILBUR E. JOHNSTON, Phar. D.
RAYMOND E. JOHNSTON, B.S.

178 ANGELL STREET
PROVIDENCE, R. I.
GAspee 1-2512
Pharmacy License #225

Patronize Journal Advertisers

Progress Notes . . .

THE MANAGEMENT OF COMMON THYROID PROBLEMS*

HERBERT A. SELENKOW, M.D.

The Author. *Herbert A. Selenkow, M.D., of Boston, Massachusetts. Associate in Medicine and tutor in Medical Science, Harvard Medical School; Senior Associate in Medicine, Peter Bent Brigham Hospital, Boston.*

THE PRACTICING PHYSICIAN is not uncommonly confronted with clinical problems in the management of patients with abnormalities of growth or function of the thyroid gland. Despite the relative abundance of dietary iodide in the New England area, goitrous enlargement, both diffuse and nodular, occurs frequently in association with normal thyroid function as well as with myxedema or hyperthyroidism. Fortunately, current knowledge of the physiologic and biochemical pathways incident to thyroid hormonogenesis permits a sound, scientific approach to both precise diagnosis and specific therapy. The availability of relatively accurate laboratory procedures for definition, delineation, and measurement of diverse aspects of thyroid function, both intra- and extra-thyroidal, further increases our ability to diagnose these disorders correctly and to regulate the course of therapy with reasonable assurance.

Several excellent reviews covering current thyroid physiology correlated with diagnostic and therapeutic aspects of thyroid disorders are available. This dissertation will endeavor to amplify these basic tenets toward formulation of a rational program for management of patients with thyroid disease. Such a pragmatic approach is offered with full realization of the hazards of oversimplification, generalization, and compartmentation of rather divers and complex disorders. It is intended only as a *guide* toward solution of these problems. Each patient requires individualization and specific adjustments to his needs.

Diagnostic Considerations

Like fire, the clinical laboratory can be foe as well as friend! Despite the availability of relatively accurate specific tests of thyroid function, diagnostic misjudgments are common because: (1) chemical substances interfere with accurate determination of these tests; (2) their technical performance requires skill and competence; and (3) errors in interpretation of results are easily made. It is almost axiomatic in medicine that a laboratory test is only as good as the laboratory which performs it and the physician who properly interprets it in the light of clinical events and findings. When there is a dissociation between the clinical judgment of the physician based upon a careful history and physical examination and the results of one or more laboratory tests, it is not uncommonly found that the laboratory test either has been incorrectly performed, interfered with by extrinsic chemical compounds, or misinterpreted.

Available tests of thyroid function include such nonspecific measurements as the basal metabolic rate (BMR), serum cholesterol, creatinine tolerance and, perhaps, the photomotogram. More specific tests include the radioactive iodine uptake, the serum protein bound or butanol extractable iodine (PBI or BEI), the erythrocyte or resin uptake of radioactive triiodothyronine, the thyroid suppression test, the thyrotropin stimulation test, and measurement of serum thyroglobulin autoantibodies. Most physicians are familiar with the technical and medical problems associated with performance and interpretation of the BMR and serum cholesterol determinations. These tests do not actually measure degrees of thyroid function but rather the effects of thyroid hormones as well as numerous other biochemical processes upon oxygen consumption or cholesterol metabolism. Most of the diagnostic difficulty usually involves an understanding of the more complex but highly specific and individualized thyroid tests.

The radioactive iodine uptake test, now performed in most hospitals, is a measure of the radioisotope I^{131} remaining in the thyroid gland at a specific interval of time, usually 24 hours. Normal values for this test vary somewhat in different laboratories but the usual range is generally given as:

0 to 15 per cent	Hypothyroid range
15 to 50 per cent	Euthyroid range
Over 50 per cent	Hyperthyroid range

Correct interpretation of the results of this test must take into consideration that iodide-containing compounds such as organic radio-opaque dyes compete with the I^{131} administered. Factitiously low

*Presented at the Sesquicentennial Meeting of the Rhode Island Medical Society, at the Marvel Gymnasium, Brown University, on May 9, 1962.

uptake values are usually caused by iodide interference because of isotope dilution or biochemical inhibition of thyroid hormonogenesis (Wolff-Chaikoff effect). Thus, following a cholecystogram, intravenous pyelogram, bronchogram, or other diagnostic radiologic procedure employing such dyes, the radioiodine uptake test may be factitiously low for a month to many years, depending upon the duration of the increased iodide pool. Further, certain non-iodine drugs may alter thyroid function, either by intention (such as propylthiouracil or thyroid) or by coincidence (such as para-aminobenzoic acid or butazolidine). Such compounds reduce radioiodine uptake and render difficult an accurate interpretation of the test.

Similarly, radio-opaque dyes and iodide-containing drugs raise the levels of serum organic iodide and thus increase the protein bound and butanol extractable iodine values. The butanol extractable iodine determination will assist in indicating the serum hormonal iodine value in the presence of low levels of iodide but will not differentiate organic iodine compounds (which are butanol soluble) from thyroid hormones present in serum. Heavy metals, such as mercury or copper, cause factitious reduction in the serum protein bound or butanol extractable iodine result. Thus, for one to several days after an injection of a mercurial diuretic, the serum iodine level may be reported falsely low because of interference with the colorimetric determination by the mercury.

Recently, the erythrocyte uptake (RBC-T3) test has been developed to avoid the problems of interference associated with the radioiodine uptake or serum iodine determinations. The RBC-T3 test does not measure intrathyroidal iodine pathways or serum iodine levels, but rather the binding capacity of the serum proteins for radioactive triiodothyronine. This test is not altered by iodine compounds or heavy metals and is useful when such artifacts interfere with proper interpretation of the radioiodine uptake or serum iodine tests.

The thyrotropin stimulation test (TSH test) is useful in differentiating primary thyroid failure from pituitary insufficiency. This differentiation is at times difficult, both clinically and by laboratory studies. However, it is imperative that patients with myxedema secondary to pituitary failure *not* be started on thyroid therapy until adrenocortical insufficiency has been corrected by appropriate steroid replacement therapy. If not, the rise in metabolic rate induced by thyroid administration may precipitate an Addisonian crisis. The TSH test may be helpful in such a differentiation. It is usually performed by giving 10 to 30 units of thyrotropin (Thytropar,® Armour) intramuscularly in one to three divided doses. If the radioactive iodine uptake increases significantly following TSH stimulation (usually more than 10 per cent above the basal value) or if the PBI rises 1.0 ug. per cent or more, this is indicative of existing thyroid tissue and suggests pituitary insufficiency. On the other hand, failure to respond to TSH does not of itself indicate primary thyroid failure, but may result from relative refractoriness of the thyroid. If the TSH test is inconclusive, other studies should be undertaken to assure the correct diagnosis.

Another test of thyroid function which is particularly helpful in diagnosing hyperthyroidism is the thyroid suppression test. This is performed by comparing the thyroidal radioactive iodine uptake before and after oral administration of *l*-triiodothyronine 100 pg. daily for seven days. If, following this dose of *l*-triiodothyronine, the 24-hour radioactive iodine uptake fails to fall below 20 per cent in 24 hours, this is strongly indicative of hyperthyroidism. This test is also quite useful in prognosticating the success or failure of antithyroid therapy, as will be mentioned later.

In general, the specific tests of thyroid function are of inestimable value for evalution of a clinical diagnosis. If the clinical impression and laboratory findings conflict, this indicates either the need for re-evaluation of the clinical status of the patient, or, more often, further studies to obviate whatever is interfering with the divergent laboratory test.

Therapeutic Considerations

Hypothyroidism. In its usual florid form, hypothyroidism or myxedema is almost always suggested by the clinical appearance or complaints of the patient. Unfortunately, in the minds of many physicians, the syndrome of the middle-aged housewife with fatigue, obesity, constipation, and a low normal BMR is too often mistaken for thyroid insufficiency. This latter syndrome does not respond to thyroid replacement therapy in physiologic doses, nor does the BMR increase permanently with such treatment. This syndrome has been variously labeled the "twilight zone of hypothyroidism" or, just as incorrectly, the "hypometabolic syndrome."

In true hypothyroidism or myxedema, response to therapy is predictable and extremely gratifying both to patient and physician. Therapy is usually begun in small doses in patients above the age of 30. Starting with daily oral doses of 15 to 30 mg. of USP thyroid, increments of 15 to 30 mg. can be made at two- to three-week intervals. A daily maintenance dosage of 120 to 180 mg. (2 to 3 gr.) is full physiologic replacement; on this regimen, the signs and symptoms of myxedema will have completely disappeared in a few weeks to two months. In general, there is usually no advantage to using the more rapid acting preparation, *l*-triiodothyronine. Approximately 120 to 180 mg. USP thyroid is

continued on next page

therapeutically equivalent by mouth to 0.3 to 0.4 mg. *l*-thyroxine (Synthroid®) or 0.1 to 0.15 mg. *l*-triiodothyronine (Cytomel®).

The previously mentioned necessity for differentiating pituitary myxedema from primary thyroid failure cannot be overemphasized. Thyroid therapy administered to patients with panhypopituitarism can induce acute adrenocortical insufficiency unless adequate replacement with adrenal steroids is first given. The water loading test, the intravenous ACTH test, the SU-4885 test (Metopirone test), and urinary FSH levels can be of great assistance in this differentiation.

Hyperthyroidism. The usual patient manifesting hyperthyroidism presents little difficulty in diagnosis if time is taken for a thorough history and physical examination. The clinical appearance of such patients is so striking that their friends often offer the correct diagnosis before the patient is seen by the physician. However, there is one group of patients with hyperthyroidism in whom the disorder is masked by manifestations of heart disease (so-called "cryptic" or "apathetic" hyperthyroidism or "thyrocardiac" disease). Such patients are often in the age group above 50, may not have a palpable goiter, ophthalmopathy, or indeed any of the cardinal features associated with Graves's disease. Some clinical clues to the diagnosis in such patients with heart disease are: (1) failure to respond to digitalis, diuretics, and a well-planned cardiac regimen; (2) unexplained *paroxysmal* or fixed atrial fibrillation; (3) a normal or even increased cardiac output in the presence of congestive heart failure; and (4) a good appetite and sense of well-being out of proportion to the degree of cardiac decompensation. Hyperthyroidism may mimic acute rheumatic fever or mitral stenosis with diastolic murmurs, prolonged P-R intervals on electrocardiogram, and a "friction rub" precordial sound. Any suggestion of possible hyperthyroidism in a patient with manifestations of heart disease is a mandate for further studies to rule out this treatable cause of heart failure.

When the diagnosis of hyperthyroidism has finally been established, the particular therapy best suited to the individual patient must be selected on the basis of careful medical judgment as well as the patient's ability to carry out the prescribed treatment. Once a therapeutic program is undertaken, adjunctive measures such as rest, sedation, nutritional supplementation and, if indicated, a rigorous regimen of cardiac management must be followed.

Although generalizations concerning selection of an appropriate form of therapy for all individuals are presumptuous, perhaps the following basic principles may provide some assistance in this regard. The three major therapeutic choices are antithyroid drug therapy, subtotal thyroidectomy subsequent to appropriate medical preparation, and radioactive iodine therapy.

Antithyroid Therapy. In young patients with hyperthyroidism, particularly below the age of 20, long-term therapy with antithyroid drugs is the treatment of choice. The program should be directed toward remission of the hyperthyroidism and requires the patient to continue medication for 18 months to two years. In this age group there is probably a 60 per cent or better chance of a sustained clinical remission with such therapy. If this fails, elective subtotal thyroidectomy usually is then indicated. For a successful medical course, it is advisable to start the patient on propylthiouracil 100 mg. or methimazole 10 mg. every eight hours for the first six months or so. As soon as the patient begins to improve, as judged by slowing of the pulse and a significant gain in weight, USP thyroid 120 mg. daily should be added to the program. This obviates drug induced hypothyroidism and prevents further goiter formation. In addition, it appears to be beneficial in arresting thyrotoxic ophthalmopathy.

The antithyroid-thyroid combination is usually continued for six to eight months. After this time, the dosage of propylthiouracil is reduced stepwise at four-month intervals to 200 mg., 150 mg., 100 mg., and 50 mg. daily in divided doses. The 120 mg. of USP thyroid is continued throughout this period and for at least a year after discontinuance of the antithyroid compound. Three months following discontinuance of the antithyroid compound and while the patient is still receiving USP thyroid (120 mg. daily), a radioactive iodine tracer test (suppression test) can be performed. If the 24-hour uptake is *above* 20 per cent at this time, it is strong evidence that a recurrence of thyrotoxicosis is imminent; if *less* than 20 per cent in 24 hours, a long remission or cure can be anticipated.

The management of hyperthyroidism during pregnancy presents special problems. In such patients it is of particular importance to employ a combined antithyroid-thyroid program. The dose of antithyroid compound should be kept at the minimum which maintains the patient's metabolic rate at a level consistent with that stage of pregnancy. Replacement doses of thyroid are then added to protect the fetus from the goitrogenic action of the antithyroid therapy. When a combined program is judiciously followed, there is usually no need for subtotal thyroidectomy at any time during pregnancy. Radioactive iodine therapy is not indicated during pregnancy.

Combined therapy for hyperthyroidism is also useful in the preparation of patients for subtotal thyroidectomy. Addition of 120 mg. USP thyroid to the antithyroid drug program during preoperative preparation provides a firmer and less

succulent gland at surgery. Iodine preparations are given in the usual manner for 10 days prior to surgery for their involutional effect on the gland.

Subtotal Thyroidectomy. Whether considered the treatment of choice at the outset or after failure of medical therapy, subtotal thyroidectomy must be performed as an *elective* procedure despite the technical skill and excellence of the surgeon. This should be preceded by at least three to six months of intensive antithyroid therapy, preferably in combination with thyroid supplementation as previously described. Optimally, the longer the patient is maintained in the euthyroid state prior to surgery, the less is the likelihood of postoperative thyroid "storm" or malignant exophthalmos. Only when the patient has recovered fully from the catabolic effects of hyperthyroidism should surgery be undertaken. At that time, both the anesthesia and the technical aspects of the subtotal thyroidectomy will be essentially the same as those used for excision of a nontoxic goiter.

It is beneficial to place preoperative patients on mild sedation with barbiturates or reserpine. If the latter is employed, it is important that the anesthesiologist be so informed. There is a tendency for reserpinized patients to respond poorly to surgical stress presumably because of depletion of tissue catecholamine stores.

After recovery from surgery, it is often beneficial to continue thyroid replacement therapy for a year or so. This has the effect of stabilizing the patient's metabolic course by preventing clinical hyperthyroidism and has the added benefit of permitting the use of the suppression test if needed for evaluation of persistent or recurrent hyperthyroidism.

It cannot be stressed sufficiently that subtotal thyroidectomy must be performed as an *elective* procedure at a time when the patient is fully euthyroid for at least three months. If thus managed, the complications are minimal and the benefits to both patient and physician are maximal.

Radioactive Iodine. Patients beyond the child-bearing age or those in whom other forms of therapy are not feasible are excellent candidates for radioactive iodine therapy. This isotopic form of radiation ablative therapy is effective, easily administered, and relatively less expensive than either long-term medical therapy or surgery. It has none of the usual complications of subtotal thyroidectomy such as recurrent laryngeal nerve palsy, hypoparathyroidism, or postoperative hemorrhage. Its use is not restricted to diffuse goiters with hyperthyroidism since multinodular goiters also respond satisfactorily. Its major limitation results from our uncertainty concerning radiation to the gonads upon genetic determinants. For this reason, many physicians limit radioiodine therapy to patients beyond the child-bearing age, usually arbitrarily given as 40 years. Many clinics, however, have recently lowered this limit and now treat many adults with radioactive iodine irrespective of age.

Patients receiving antithyroid therapy for hyperthyroidism who are subsequently selected for radioiodine must discontinue the antithyroid compound five days or more prior to isotopic administration. If they are receiving combined antithyroid-thyroid therapy, it is not necessary to discontinue the thyroid medication. The hyperthyroid gland continues to take up I^{131} despite the use of thyroid medication. As with subtotal thyroidectomy, it is often beneficial to continue USP thyroid 120 mg. daily for a year or so following radioiodine treatment.

Goiters, Nodules and Cancers. It is with some hesitancy that the problem of goiters, thyroid nodules, and thyroid cancer is approached during such a pragmatic perusal of common thyroid problems. The management of lumps in the thyroid gland is controversial and requires the best judgment of the physician. Since accurate, reliable scientific information concerning the natural history of thyroid tumors is not available, precise determination of which goiters may be cancerous and which benign cannot be made with anything but arbitrary selection. There are those physicians who feel that all thyroid masses should be surgically removed either because they are already malignant or are potentially so. To follow such a course would require removal of all thyroidal enlargements since, without histologic assistance, no reliable selection can be made clinically. Selection notwithstanding, this is obviously an insurmountable task since goiter is extremely common. Further, the number of thyroid cancers found by such a program would be quite small since thyroid cancer is uncommon. In addition, most thyroid cancers are of the papillary or follicular varieties and the morbidity and mortality rates from such cancers are extremely low. The course of undifferentiated varieties of thyroid cancer, which are highly malignant and usually rapidly fatal, is not benefited either by surgical removal or radiation therapy. In light of this, many physicians are now taking a more conservative approach to the problem of thyroid cancer prevention and treatment.

It seems reasonable, in view of the relative benignity of thyroid neoplasma and the evidence suggesting that thyroid tumors are "hormonally dependent," that only young individuals (under 35 years) with single nodules of the thyroid be advised to have simple excision of these nodules. If malignant, radical neck dissection or radiation therapy need not be performed. On the other hand, if the goiter is multinodular or if the patient is above 35 years of age, suppressive therapy with 180 mg. USP thyroid appears to be the treatment with the least risk and the greatest reward. There is no substantial evidence that surgical removal of thyroid cancers with

concluded on page 570

INJURIES DUE TO ILL-FITTING PROTECTIVE ATHLETIC EQUIPMENT*

ALLAN J. RYAN, M.D.

The Author. *Allan J. Ryan, M.D., of Meriden, Connecticut. President-elect, American College of Sports Medicine; Member, Committee on Medical Aspects of Sports of the American Medical Association.*

NO MATTER WHAT CARE is exercised, it is impossible to protect the athlete against every possible injury. We know by experience, however, that many minor injuries can be prevented by the use of protective equipment. Once this equipment enters the picture several new factors are introduced into the injury situation. First, the equipment may not be sufficiently strong or protective to do the job required. Second, the equipment must be properly fitted and applied to the athlete in order to afford the protection for which it is designed. Third, the equipment must be kept in place as it is initially applied. Fourth, the equipment may satisfy the first three requirements but yet because of its nature or effect in action pose an additional hazard to the athlete wearing it or to another competitor.

These matters cannot be left entirely to the coach, trainer, manufacturer's representative, and the athlete himself. The team physician must learn about them and take an active interest in coping with the problems that arise. He is the one who has to treat the injury when it occurs, and should therefore have, next to the athlete, the greatest interest in preventing it.

Protective equipment may be as simple as a foam pad or as elaborate as a double cantilever shoulder pad. It may be constructed for each use out of simple materials such as adhesive tape and felt, or it may be designed for repeated use over a long period of time such as a ski boot. It may be an item used by every player, such as a football helmet, or one used only rarely, such as a restraining shoulder harness.

Probably the most convenient way to consider some of the problems posed by the use of protective equipment is to take them up in relation with the part of the body to be protected starting with head and working downward. We will try to give attention particularly to the team contact sports and to a few other situations where a serious hazard may be presented.

*Presented at the Second Conference on Sports Injuries for Athletic Department Personnel of Secondary Schools in Rhode Island, under the auspices of the Rhode Island Medical Society, at the Hunter Laboratory of Psychology, Brown University, Providence, R. I., September 10, 1962.

Function of Helmet

The functions of a helmet in athletics are to prevent contusions, abrasions and lacerations and to absorb to some extent the force of blows directed by another individual, or a moving or stationary object. The helmet must be designed to follow the contours of the head in order to perform its specialized purpose in each sport. Since these contours are irregular and since the helmet must be supported by its contact with the head itself, it follows that it can only perform its functions if it is worn in exactly the position for which it was designed to fit the head. The situation is complicated by the fact that human heads occur in such a great variety of shapes and that effective helmets must be semi-rigid to very rigid in construction. As a practical matter the number of molds which the manufacturer can use must be limited. The inconsistencies in shape must be compensated for by the elasticity of the interior suspension and padding of the helmet.

The most obvious possibility for injury due to helmet failure occurs when the helmet is knocked off. This may happen because the helmet is too large or the chin strap has not been properly fitted. All chin straps should be checked periodically to make sure that they fit snugly and that neither strap or fastener is so damaged that it may break away.

When the helmet does not fit snugly to the head, it may be twisted around so that the side of the helmet comes in front of the face. In this position the suspension system becomes relatively ineffective and, if a further blow is received, the helmet may then bottom sharply on the head provoking a concussion or a fracture. The temporal region of the skull or the opposite side is exposed at the same time to the effects of direct trauma. It may also be forced backward on the head in such a way that the lower edge of the helmet cuts into the neck at the base of the skull. This is not exactly the same mechanism as that alleged by Doctor Schneider to occur when the head is forcibly hyper-extended on the neck with the helmet in position, since the edge would then strike further down and with more force. The most that could be expected to occur in

the former injury would be a contusion or laceration of the neck. The forehead would, however, be exposed to direct trauma and the mouth and possibly the nose exposed due to the shift in the face guard.

The face guard itself should be fitted to the helmet so that it is just far enough in front of the nose and mouth not to touch them when a severe force is applied to it. If the guard is placed too far out, too much room is left for a knee, elbow, or fist to enter between it and the rim of the helmet. It also allows a greater possibility of its being grabbed accidentally or deliberately or its serving as a lever on contact with the ground to cause a twisting action of the head on the neck, twisting of the neck itself, or distraction of the head and neck from the shoulder on the same side as the blow. In its least serious form this may cause a strain of the neck; in its most serious form, a brachial plexus strain or a cervical fracture.

Mouthpiece Must Be Fitted

The mouthpiece must of course be fitted to each individual player by a dentist. If it is too loose it will fall out of place or perhaps even out of the mouth or back into the throat. In the former instance dental injury may result, in the latter, strangulation. It was recently pointed out by a coach that some players had had their dental guards cut down at each end so as to protect only the front teeth. This posed not only an additional hazard to the exposed teeth but of strangulation, since the smaller piece could easily be forced not only into the pharyngeal opening but down against the larynx.

The shoulder pad in football, hockey, or lacrosse is designed to protect principally against three injuries, the "shoulder pointer" or contusion at the acromio-clavicular junction, the "shoulder separation" or acromio-clavicular separation, and fracture of the clavicle. In order to fulfill this function the pads must be large enough so that they extend out over the head of the humerus, but not so large that they become loose on the shoulders, and come down far enough over the chest and back so that when properly fastened they cannot be easily moved out of position. Just as in the case of other similar equipment a pad which fitted perfectly when new may fit poorly when badly worn, or when not properly laced or fastened. Straps which are stretched and laces which are broken contribute to poor fit.

Blocker's pads on the upper arms are effective only if they are applied in such a way as to cover the insertion of the deltoid muscle. They should be securely fastened to the shoulder pad and the arm. Displacement of the pad will not cause injury itself if they are made of the closed-cell foam but may allow it by leaving the area unprotected.

Not all football players wear rib pads. If these are made in the form of a rib belt, it is of course essential to make sure that they are put on right side up and applied snugly.

The baseball catcher and hockey and lacrosse goalies wear chest and abdominal protectors. Some attention should be given to the size of these protectors relating to the size of the player using them. A big man cannot safely use the protector which fits a small man perfectly. Again, worn or broken straps can cause the protector to fit imperfectly and expose an area which should be protected. These three players also wear protective masks, each of a different design and construction. It is essential that the mask be of adequate size to cover the face, and that clearance of the nose and mouth be sufficient to allow the mask to absorb the impact.

Hip Pads Present Problem

Hip pads present one of the greatest problems in protective equipment as far as maintaining their correct position is concerned. If they are fixed to the trousers, the trousers must be worn as they were designed to be, high around the waist, not dragging down over the hips as many young men like to wear their pants today. Abrasions and "hip pointers" cannot be prevented if the hip pads are not kept in place. The lightweight nylon girdle with built-in plastic foam pads provides a good answer to this problem. If a coccygeal pad is being used, it should be large enough to fit down over the full length of the coccyx, a very variable distance.

Thigh pads which are fitted into pockets in the trousers are again dependent on the proper positioning of the trousers for the protection against hematomas which they may offer. A torn pocket may mean a displaced pad. After the trousers have been stretched it may be necessary to use circumferential tape above and below the pad to hold it in proper position. Goalies in hockey and lacrosse wear external pads which fit over the thighs and legs. The chief defect in fitting this type of pad is to make it too skimpy, allowing injuries to occur in unprotected areas.

The knee and leg protector of the baseball catcher must be fitted so that the patella is completely covered in the full squatting position. These protectors take hard use and should be checked frequently for proper fit. The knee protector of the basketball player will stay in place only if the elastic which holds it is not overstretched, as it may be with long use or in transferring the protector from one player to another.

The Shoe as Protective Equipment

Certain injuries are common to any of the variety of specialized athletic footgear. Many persons do not think of a shoe as being a piece of protective equipment. Only the spiked running shoe can be

concluded on next page

truly said to be a solely functional piece of equipment. If races were run on grass there would be no need of shoes for protective purposes. The rubber soled distance running shoe for road races is protective, in spite of the fact that boys and men from some countries where it is still common to go barefoot will not use them.

Blisters are the most common foot injury. They may be due to ill-fitting shoes but not always so. Feet must be compressed or distorted in a variety of ways to fit into the standard lasts and sizes. Corns and calluses may also result from poorly fitting shoes. Special attention should be given to the feet during the early part of each athletic season. Early treatment of these foot ailments and the institution of correctional measures will save lost days and decreased efficiency during the most active part of the season.

Socks which do not fit properly because of their size, overstretching or too much shrinkage after washing, or because of unmended holes, can help to form blisters. Prevention may require wearing a light close-fitting pair under the sweat socks and using a light coating of mineral oil on the sole of the foot to prevent sticking.

The argument still goes on as to whether the high-cut football shoe provides better protection than the low-cut shoe. If the ankle is wrapped or taped there is probably not much difference between the two. It has been noted in the case of skiers, however, that when a very heavy and semi-rigid boot is used to protect the ankle, the twisting forces in a fall are transmitted to the Achilles tendon, which may rupture just above the boot, or to the tibia which suffers a spiral fracture. This provides an unusual example of a piece of equipment which may be perfectly fitted and yet provoke an injury while protecting against another.

The glove is a piece of protective athletic equipment which may allow an injury by virtue of its absence. Since gloves are pulled off for one reason or another by athletes more often than they slip off, it is hard to assign very many injuries to a poorly fitted glove. Because of the awkwardness, an athlete is less likely to wear a poorly fitted glove than a poorly fitted shoe.

Taping, strapping, or other bandaging for protection which is poorly applied may be the cause of an injury which might otherwise be avoided. This is particularly true in the taping or wrapping of an ankle.

SUMMARY

The most expensive piece of athletic equipment may offer only poor protection if it is not properly fitted. The protective equipment which has slipped out of place because it was not properly applied or worn out is a menace rather than a help to the athlete. The helmet which is lying on the ground won't protect the player whose head it came off and may cause an ankle sprain or worse to the one who steps on it. Fads which cause athletes to wear equipment in ways for which it is not designed have no place in athletics, particularly in contact sports.

MANAGEMENT OF COMMON THYROID PROBLEMS

concluded from page 567

or without neck dissection or postoperative radiation improves survival. Until such time as this evidence is presented, a conservative approach is indicated.

SUMMARY

In summary, several points are worthy of reemphasis:

1. Most disorders of thyroid size or function are clinically recognizable and, if properly diagnosed, respond well to relatively simple therapeutic programs.

2. All obese, tired women with low BMR's do not necessarily have myxedema. If a hypothyroid patient fails to respond to adequate physiologic dosage of USP thyroid, the accuracy of the original diagnosis should be reconsidered.

3. Exclude pituitary myxedema before instituting thyroid hormone replacement therapy.

4. Insist that hyperthyroid patients who are being prepared for subtotal thyroidectomy are given an adequate and prolonged period of euthyroidism with stable ophthalmopathy prior to surgery.

5. Select hyperthyroid patients for medical, surgical, or isotopic therapy with equanimity. Those selected for medical long-term or preoperative therapy will benefit by a combined antithyroid-thyroid regimen.

6. Suspect thyrocardiac disease in patients manifesting idiopathic atrial fibrillation, sinus tachycardia, or those in congestive heart failure of the high output variety.

7. Consider a cautious and conservative approach to the surgical treatment of thyroid nodules and goiter.

8. Use all the laboratory and diagnostic facilities at hand with prudence and careful deliberation. Do not hesitate to rely on sound clinical judgment.

Bibliography

The Thyroid, Werner, S. C., ed., 2nd ed. New York. Hoeber-Harper, 1962

Hamolsky, M. W., and Freedberg, A. S.: The thyroid gland. New England J. Med. 262:23, 70, 129, 1960

Ingbar, S. H.: Physiologic considerations in treatment of diffuse toxic goiter. A.M.A. Arch. Int. Med. 107:932, 1961

Selenkow, H. A., and Collaco, F. M.: Clinical pharmacology of antithyroid compounds. Clin. Pharmacol. & Therap. 2:191, 1961

Selenkow, H. A., and Marcus, F. I.: Masked hyperthyroidism and heart disease. Med. Clin. North America 44:1305, 1960

Clinical Endocrinology, I, Astwood, E. B., ed. New York. Grune & Stratton, 1960

Editorials

HOSPITAL ACCREDITATION

Several recent articles in the local and national press and in certain popular magazines have focused public attention on the importance of hospital accreditation. The over-all problem of accreditation in this state has perhaps been too little regarded by the profession here.

An examination of the status of nongovernmental hospitals in Rhode Island elicits the unpleasant intelligence that at least four institutions of this description lack recognition by the accrediting agency. The Joint Commission on Accreditation of Hospitals, although a nongovernmental, nonprofit agency, has prestigious sponsorship. The sole responsibility for inspection of hospitals was formerly for many years borne by the American College of Surgeons. Some years ago this important task was assumed jointly by the American College of Surgeons, the American College of Physicians, the American Medical Association, and the American Hospital Association. Their agent, the Joint Commission, operates solely for the purpose of improving and standardizing at an adequately high level the care of patients within hospitals. All of the major hospitals in Rhode Island have been duly accredited. Both state and federal hospitals have found it worthwhile to seek accreditation. Several state hospitals have achieved accreditation, as has the United States Veterans' Administration Hospital at Davis Park.

Of the four unaccredited hospitals referred to, two are members of the Rhode Island and American Hospital Associations, and two are not. One of the latter is not eligible for either accreditation or membership in the Hospital Association because its staff (according to definitions of the American Medical Association) practices cult medicine. Three of the four hospitals are voluntary nonprofit institutions, while one is a profit-making venture. According to the listing of the American Hospital Association, the latter, besides not being accredited or a member of the Hospital Association, has no blood bank and no laboratory for pathology (although major surgery is performed there), no pharmacy, and no premature nursery (although it has an obstetrical service). One of the important reasons for failing to achieve accreditation is inadequate numbers of attendants, particularly nursing. This deficiency is usually not documented in public listings. Raising of standards, of course, including the hiring of more help, costs money. Also unlisted is a private maternity "hospital" in a converted house which seems to have survived by remaining peculiarly inconspicuous. Such an institution is little more than a nursing home with a pretentious name, and could not survive if it were required to maintain modern high hospital standards. It is almost axiomatic that a good hospital cannot make a profit.

Licensing of hospitals in Rhode Island is a responsibility of the State Department of Health. Standards for licensing are presumably determined within the department with the advice of an advisory committee.

Recent studies elsewhere of hospital performance have indicated that proprietary hospitals provide, on the whole, poorer care than nonprofit institutions. A study of New York hospitals by the Columbia University School of Public Health made at the request of Teamster Joint Council No. 16 and Management Hospital Trust Fund revealed that 64 per cent of patients in nonprofit hospitals received good or excellent care, compared with only 39 per cent in proprietary hospitals. These discouraging statistics should be a matter of general concern, but in the present context we have reference to the comparative values, which are very significant.

What can be done to assure high hospital standards in Rhode Island? Two types of pressure are being applied in other areas, which may have application in this state. The New York City Department of Hospitals under the energetic direction of Doctor Ray E. Trussell has recently effected a general tightening of its licensing regulations, and in addition after 1965 will require accreditation by the Joint Commission as a prerequisite for a license. Two Blue Cross plans, those of Michigan and Northeast Ohio, deny member-hospital status to profit-making institutions. The Michigan and Chicago Blue Cross organizations require Joint Commission accreditation for member status, and New York's Associated Hospital Service (Blue Cross) will require accreditation after 1963. These are measures which should be entertained seriously by the Rhode Island State Department of Health and by Blue Cross of Rhode Island.

continued on next page

END OF AN ERA?

THE J.A.M.A. of August 11, 1962, carried an announcement that Doctor Richard B. Cattell had resigned as director of the Lahey Clinic in Boston. The Lahey Clinic has had in its long history only two directors, the late Doctor Frank H. Lahey, its founder, and Doctor Cattell. Under their distinguished leadership it has contributed substantially to good medical practice in America and in the world. Although the Clinic did not often make contributions of a profoundly fundamental nature, its application of sound and progressive principles in medicine and notably in surgery has helped to mold modern medical practice and thought. Simple and logical formulations were the stock in trade of both Doctor Lahey and Doctor Cattell. That they were brilliant technicians needs no emphasis. We are concerned here more with their broader influence.

While the medical literature has been replete with technical articles of a complexity to render them almost unintelligible to the humble clinician, the Lahey group have continued to compose papers which are readable and sensible. An example of this type of clinical study is a paper by Warren, Cattell, Blackburn, and Nora titled *A Long-term Appraisal of Pancreaticoduodenal Resection for Peri-ampullary Carcinoma* presented before the Southern Surgical Association in December, 1961. In this review of 218 cases, probably one of the last major papers in which Doctor Cattell will have participated, the conclusions, as usual, are simply and cogently stated:

"These data indicate the importance of differentiating peri-ampullary carcinomas according to the site of origin and with respect to the pathologic type of tumor. The prognosis in cases of primary carcinoma of the pancreas is poor while the outlook for significant palliation and for cure is good in carcinoma arising in the distal common duct, the duodenum and the ampulla of Vater."

Doctor Alton Ochsner in the Fourth Annual Frank H. Lahey Memorial Lecture on *Treatment of Ulcerative Lesions of the Stomach and Duodenum*, stated: "Only if the conservative treatment [of duodenal ulcer] fails or if a surgical complication develops should an operative procedure be resorted to. . . . I prefer the gastric resection [to vagus resection] because it has stood the test of time and will continue to stand the test of time." Although admitting that another ten or fifteen years might change the status of vagus operations, he concluded: "I am sure Frank Lahey would [agree with me] if he were here." There is no doubt that Richard B. Cattell did.

There is some indication that this type of balanced conservatism may be expected from our good neighbor in the foreseeable future. An editorial with the reasonable title *All Change Is Not Progress* recently appeared in SURGERY, GYNECOLOGY, AND OBSTETRICS from the pen of Doctor Bentley P. Colcock of the Clinic. On the subject of duodenal ulcer he holds, predictably, that a 70 per cent Hofmeister resection is the procedure of choice, although allowing that vagotomy has a limited place, sometimes in combination with subtotal resection. On the subject of rectal carcinoma he concludes after analyzing available data that "It would seem that abdominoperineal resection [as against sphincter-saving procedures] remains the best treatment for most patients with cancer of the rectum." He ends his brief essay with the Biblical injunction, "Prove all things; hold fast that which is good."

Although an era has ended at the Lahey Clinic, there is good reason to believe that its sound and conservative teachings will still be heard in medical and surgical councils.

References

[1]Warren, K. W.; Cattell, R. B.; Blackburn, J. P., and Nora, P. F.: A Long-term Appraisal of Pancreaticoduodenodenal Resection for Periampullary Carcinoma. Am. Surg. 155:653, 1962

[2]Ochsner, A.: The Fourth Annual Frank H. Lahey Memorial Lecture: Treatment of Ulcerative Lesions of the Stomach and Duodenum. Lahey Clinic Bull. 12:162, 1961

[3]Colcock, B.: Editorial: All Change is Not Progress. Surg., Gynec., and Obstet. 4:494, 1962

PEACE GESTURE?

THE NEWS HEADING stated "Pension Bill Signing Seen Peace Gesture."

The bill in question was H. R. 10 which permits self-employed persons to take a federal income tax deduction for private pension plans. This is the legislation that has been battled in the Congress for twelve years, with the House twice passing it. The vote in the Democratic House this year was 361 to 0. The Senate vote was 70 to 8.

The new law authorizes a self-employed individual to contribute up to 10 per cent of his earned income, or $2,500, whichever is less, toward a retirement plan, provided he includes all of his employees with three or more years of service under the plan. A tax deduction of half of the contribution to the self-employed person's retirement plan would be allowed.

In spite of the overwhelming Congressional approval of the bill this year, the President held off signing the act into law until six hours before the October 10 deadline that he had to act on it. If he had not signed it then it would have become law

without his signature, unless the Congress had adjourned, when it would be a pocket veto.

The news story out of Washington via the wire services stated that

> The news story out of Washington via the wire services stated that
>
> "The fact that the President wasn't very pleased with the bill seemed to be substantiated by his silence in signing it. The usual White House statement and ceremonies which accompanies such actions were conspicuously missing . . .
>
> "Mr. Kennedy has been represented as being angry at the doctors who joined in the campaign that ended in the Senate defeat of his proposal to finance health care for those over 65 through Social Security taxes . . ."
>
> "But sponsors of the measure had argued with him that giving the doctors something most of them want might help ease their opposition to his general program, if not to the health care item."

The ridiculous part of such a theory lies in the fact that the new law benefits *every* self-employed person. Some 19 million persons, according to Senator Everett M. Dirksen, will be affected by the measure. Physicians in all categories represent less than three per cent of the self-employed.

Let's keep the record clear. A federalized compulsory health program is wrong for the good reasons that doctors and a great majority of other citizens have stated, and no doctor is changing his views on that bill for limited tax relief on a self-employed pension plan that industry and management has enjoyed in far more liberal manner for many years.

DOCTOR'S OFFICE

Reception Room, Consultation Room,
Three Large Examining Rooms,
available
December 1, 1962, at
339 Thayer St., Providence 6, R. I.

Apply to:
EZRA SHARP, M.D.
339 Thayer Street, GAspee 1-1751

We Offer the Finest Facilities for
CONVENTIONS, SEMINARS, CONFERENCE MEETINGS
1 to 400 persons
NEW MOTOR INN and ALL FUNCTION ROOMS
FULLY AIR-CONDITIONED
Outdoor Swimming Pool, Boating, Fishing, Golfing,
Historic Mansions, World Famous Ocean Drive
Viking Hotel and Motor Inn
"in the center of everything"
NEWPORT, RHODE ISLAND
Telephone 847-3300

AIR AMBULANCE SERVICE

To any part of the country — day or night. Multi-engine equipment, air line rated pilots. Fully equipped amblance, stimulant tray, oxygen therapy etc. Registered nurse on all trips. We can transport stretcher cases in and out of the smallest airports.

No increase in rates over ground transportation

CUSHMAN'S
AIR AMBULANCE SERVICE

47 NISBET ST., PROVIDENCE, RHODE ISLAND
Call DE 1-4840



Health Havens
100 WAMPANOAG TRAIL
EAST PROVIDENCE, R. I.
438-4275

A Truly Modern, Intermediate Care Facility Providing the Ultimate in Nursing Home Care at Reasonable Rates

Prepared to accept and adequately care for many acute cases as well as the more general convalescent and nursing home patients. We are limited to adults.

Our Nursing Administrator, Mary E. Baxter, R.N., will be pleased to discuss patient care with you.

HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY
Report of Meeting Held September 26, 1962

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, September 26, 1962. The meeting was called to order by the president, Doctor Arthur Hardy, at 8:07 P.M.

The secretary read a communication from Doctor J. Merrill Gibson reporting the appointment of Doctor Joseph Lambiase as a delegate from the Providence Medical Association in place of Doctor J. Merrill Gibson, Jr., who has moved out of the district, and the appointment as alternate delegates for this meeting of Doctor J. P. Eddy for Doctor Wilfred Carney, Doctor Harold Williams for Doctor Robert R. Baldridge, and Doctor Edward I. Seltzer for Doctor Waldo Hoey, as the appointed delegates were unable to attend the meeting.

The following delegates were in attendance: *BRISTOL COUNTY:* Robert W. Drew, M.D. *KENT COUNTY:* Peter C. Erinakes, M.D.; Edmund Hackman, M.D.; George Young, M.D., and John M. Vesey, M.D. *NEWPORT COUNTY:* Philomen Ciarla, M.D. *PAWTUCKET DISTRICT:* Edmund Billings, M.D.; Philip Lappin, M.D.; Earl J. Mara, M.D.; Robert C. Hayes, M.D., and Earl F. Kelly, M.D. *WASHINGTON COUNTY:* Joseph Ruisi, M.D., and Freeman B. Agnelli, M.D. *WOONSOCKET DISTRICT:* Edward B. Medoff, M.D.; Joseph Bliss, M.D., and Saul Wittes, M.D. *OFFICERS OF THE RIMS* (other than delegates): Arthur E. Hardy, M.D.; Thomas Perry, Jr., M.D., and Michael DiMaio, M.D. *DELEGATE TO A.M.A.:* Charles J. Ashworth, M.D. *STATE HEALTH DEPT. DIRECTOR:* Joseph Cannon, M.D. *IMMEDIATE PAST PRESIDENT OF RIMS:* Samuel Adelson, M.D. *PROVIDENCE MEDICAL ASSOCIATION:* Harold Williams, M.D. (alternate); John T. Barrett, M.D.; Irving A. Beck, M.D.; J. Robert Bowen, M.D.; Bertram H. Buxton, M.D.; Jesse P. Eddy III, M.D. (alternate); Joseph Caruolo, M.D.; Francis Chafee, M.D.; Henry Fletcher, M.D.; Warren Francis, M.D.; Frank Fratantuono, M.D.; J. Merrill Gibson, M.D.; Joseph Lambiase, M.D.; John F. W. Gilman, M.D.; Seebert Goldowsky, M.D.; Stanley Grzebien, M.D.; John C. Ham, M.D.; Edward I. Seltzer, M.D. (alternate); Walter S. Jones, M.D.; Robert V. Lewis, M.D.; William J. MacDonald, M.D.; Gustavo A. Motta, M.D.; William S. Nerone, M.D.; Francis W. Nevitt, M.D.; Arnold Porter, M.D.; William A. Reid, M.D.; Ralph D. Richardson, M.D.; Carl S. Sawyer, M.D.; Stanley D. Simon, M.D.; John Turner, II, M.D., and Elihu S. Wing, Jr., M.D.

The following delegates were absent: Doctors Charles Dotterer; James A. McGrath; J. Murray Beardsley; Robert R. Baldridge; Wilfred Carney; Waldo Hoey; Frank MacCardell, and Jack Savran.

Also present were approximately twenty members of the Society who were not members of the House of Delegates.

Report of the Secretary

Doctor Michael DiMaio, secretary, read his report, copy of which was included in the delegates' handbook.

Action: A motion was made, seconded and passed that the report of the secretary be approved and placed on file.

Resolution from the 1962 General Meeting of the Society

Doctor Hardy noted that the resolution voted at the general session held at the annual meeting on May 9, 1962 was included in the handbook.

Doctor S. J. Goldowsky read a brief statement regarding the purpose and intention of the editorial cited in the resolution.

Action: A motion was made to table the resolution received from the general meeting of May 9, 1962. The motion was seconded.

Doctors Samuel Adelson and Joseph E. Cannon were named as tellers for the written ballot on the question.

The president reported the tabulation of the ballot by the tellers as 38 "Yes" votes to table, and 9 "No" votes not to table, and he declared the motion tabled, and not open therefore to debate or discussion.

* * *

Doctor Henry M. Tyszkowski asked for the privilege of addressing the House to express the views of the Rhode Island Chapter of General Practice. The president ruled that he might address the House as a nondelegate if the House so votes.

A motion was made that Doctor Tyszkowski be permitted to address the House. The motion was seconded. The motion was defeated.

continued on page 576



For peptic ulcer gastric hyperacidity and gastritis...

In year-long study on peptic-ulcer patients

New Creamalin®
Antacid Tablets

*"...faster in onset of action...and for a longer period"**

"Clinical studies in 85 patients with duodenal ulcer ...confirmed the superiority of the new preparation [new Creamalin] over standard aluminum hydroxide preparations, in that prompt relief was achieved and maintained throughout the period of observation."*

Patients were followed for about one year.

New Creamalin promotes ulcer healing, permits less frequent feedings because it is so long-acting. Heartburn and epigastric distress were "...easily and adequately controlled...."* New Creamalin has the therapeutic advantage of a liquid antacid with the convenience of a palatable tablet. *It does not cause constipation.*

Each new Creamalin tablet contains 320 mg. of specially processed highly reactive dried aluminum gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. Minute particles offer a vastly increased surface area.

Dosage: Gastric hyperacidity—from 2 to 4 tablets as needed. Peptic ulcer or gastritis—from 2 to 4 tablets every two to four hours. *How Supplied:* Bottles of 50, 100, 200 and 1000.

Now also available—New Creamalin Improved Formula Liquid. Pleasant mint flavor—creamy pink color. Stabilized reactive aluminum and magnesium hydroxide gel (1 teaspoon equals 1 tablet). Bottles of 8 and 16 fl. oz.

Creamalin, trademark reg. U. S. Pat. Off.

*Schwartz, I. R.:
Current Therap. Res. 3:29, Feb., 1961.

Winthrop LABORATORIES New York 18, N. Y.

HOUSE OF DELEGATES

continued from page 574

Report of the Sesquicentennial Committee

Doctor Thomas Perry noted that his report had been included in the handbook, and that it was self-explanatory.

Action: A motion was made, seconded and passed that the report of the Sesquicentennial Committee be approved.

Report of the Treasurer

The president noted that the treasurer was absent, but his report had been submitted in the handbook.

Action: A motion was made, seconded and passed that the report of the treasurer be received and approved.

Recommendations of the Council

The secretary read the recommendations from the Council which were included in the handbook, as follows:

1. That Doctor Henry J. Hanley, of Pawtucket, be elected to serve a three-year term, until 1965, as a trustee of the Benevolence Fund.

Action: A motion was made, seconded and passed that the recommendation be approved.

2. That Doctor Arthur E. Hardy, of Warwick, be Delegate to the American Medical Association for a two-year term starting January 1, 1963, and that Doctor Edmund T. Hackman, of Warwick, be Alternate Delegate for the same term.

Action: A motion was made, seconded and passed that the recommendation be approved.

3. That the annual dues for 1963 for active members more than one year in practice be $60, and for members in their first year of practice, $30.

Action: A motion was made, seconded and passed that the recommendation be approved.

4. That the House express its opinion on the advisability of a poll of the membership of the Society on the question: "Should the United States Congress pass legislation to include doctors of medicine under the Social Security System on a compulsory basis?"

Action: A motion was made, seconded and passed that the recommendation be approved.

Discussion: Doctor Ashworth asked for clarification of the reason for such a poll of the membership, and the executive secretary read communications from the legal department of the A.M.A.

Action: A motion was made, seconded and passed that the Society poll its membership on the question as suggested in the Council's recommendation.

Report of the Disaster Committee

The president noted that the report of the Disaster Committee had been submitted by the chairman and was included in the handbook.

Action: It was moved that the report of the Disaster Committee be received and placed on file. The motion was seconded and passed.

Oral Poliomyelitis Program

Doctor John T. Barrett, chairman of the Committee on Mass Immunizations, reviewed the report submitted jointly by him and Doctor Rudolph Jaworski, chairman of the Child-School Health Committee, relative to a statewide oral poliomyelitis program. Copy of the report was included in the handbook.

There was general discussion of the proposed program, and Doctor Joseph E. Cannon, state director of health, reviewed the position of the public health authorities on the issue.

The question of legal protection for the Society was raised, and the House recommended that the committee carefully explore that phase of the program.

A motion to table the proposal for the oral polio program until legal advice is secured and a report is made at the next meeting of the House was defeated.

Action: A motion was made that the report made jointly by the mass immunization committee and the child-school health committee, as submitted to the House in the handbook, and the proposal for a Society sponsored oral polio program included therein, be approved. The motion was seconded and passed.

Mental Health Committee

Doctor J. Harold Williams read a report from the Mental Health Committee, copies of which he distributed to the members of the House. The report was briefly discussed.

Action: A motion was made, seconded and passed that the report of the Mental Health Committee, as submitted, be received, and that the resolution included in the report be approved.

Mediation Committee

Doctor Sargent reported that he had no additional comments to make on his brief report that was included in the handbook relative to the Mediation Committee.

Action: A motion was made, seconded and passed that the report of the Mediation Committee be approved.

Medical Aspects of Sports

The president asked for action on the report of the Committee on the Medical Aspects of Sports, as submitted to the House by the chairman.

Action: A motion was made, seconded and passed that the report of the Committee on the Medical Aspects of Sports be approved.

continued on page 578

scratching helps...



but Calmitol stops itching fast!

For every kind of pruritus—for adults or children—safe, fast-acting CALMITOL Ointment soothes itching on contact, helps prevent secondary trauma caused by scratching. And low-cost, conservative CALMITOL is non-sensitizing. CALMITOL Ointment is available at all pharmacies in 1½ oz. tubes and 1 lb. jars. For more stubborn pruritus, CALMITOL Liquid in bottles of two fluidounces.
THOS. LEEMING & CO., INC., New York 17

CALMITOL®

for anything that itches

HOUSE OF DELEGATES

continued from page 576

Medical Economics Committee

Doctor Stanley D. Simon, chairman of the Medical Economics Committee, read his report, copy of which is made part of the official minutes of the meeting.

Various phases of the report, including discussion of the Physicians Service fee schedule revisions presented to the House at its April 30, 1962 meeting, were reviewed.

Action: A motion was made, seconded and passed that the House approve the report of the Committee on Medical Economics, and that it reaffirm its approval of the Physicians Service schedule of indemnity revisions submitted to it at the April 30, 1962 meeting, and that it ask for prompt action on the revisions by the board of directors of Physicians Service.

Committee on Scientific Work and Annual Meeting

Doctor Jesse P. Eddy, chairman of the committee on scientific work and annual meeting, gave a brief oral report of progress for his committee on its plans for the scientific assembly to be held at the Marvel Gymnasium of Brown University on May 8 and 9, 1963.

Action: A motion was made, seconded and passed that the report be approved.

Committee on Publications

Doctor Alex M. Burgess, Sr., gave a brief oral report for the committee on Publications, citing in particular the loss of advertising revenue within the past year, a situation faced by many state medical association journals throughout the country. He reported that committee had referred the financial problem to the Council which will continue to study the problem.

Action: A motion was made, seconded and passed that the report be approved.

Committee on Social Welfare

Doctor Peter Mathieu, chairman of the committee on social welfare, gave an oral report of the activities of his committee, and of its plans to meet with the officials of the state social welfare department in an effort to develop a better continuity in both in- and out-patient hospital care of welfare recipients, with the in-hospital care on a private physician basis if possible.

Action: A motion was made, seconded and passed that the report of the social welfare committee be approved.

Committee on Diabetes

Doctor William L. Leet, chairman of the committee on diabetes, gave a brief oral report of progress by his committee in its plans for the annual diabetes detection campaign. He reported that diabetes fairs are planned for Providence, Warwick and Newport, and that close affiliation will be developed with various community groups to further diabetes education and control.

Action: A motion was made, seconded and passed that the report of the diabetes committee be approved.

Expansion of Executive Staff

Doctor Stanley D. Simon asked for additional information on the item in the report of the secretary relating to a study committee for the expansion of the executive office staff. The question was discussed by several members of the House, and by the executive secretary.

Action: A motion was made that it be the opinion of the House of Delegates that the executive secretary be permitted to engage adequate assistance. The motion was seconded.

A motion was made to table the motion before the House until a further report on the matter is received from the special study committee named by the Council. The motion to table was seconded, and defeated.

The original motion was withdrawn by the maker, and its second, and a motion was made that the House of Delegates go on record as urging the Council of the Society to obtain a fulltime assistant for the executive secretary. The motion was seconded and passed.

Adjournment

The House adjourned its meeting at 10:32 P.M.

Respectfully submitted,

MICHAEL DIMAIO, M.D., *Secretary*

REPORT OF THE SECRETARY

The Council has conducted two meetings since the April session of the House of Delegates. Major matters resolved included the following:

1. The mass immunization committee and the child-school health committee of the Society were authorized to formulate a plan to carry out a statewide program of mass immunization with the Sabin oral vaccine, preferably in the spring of 1963, and it requested the committees to submit their proposal to the House of Delegates at the September meeting.

2. The action taken by the president in submitting suggested nominees, from a list submitted by the Council, to the Governor for possible appointment as members of the Medical Advisory Committee to the state Workmen's Compensation Commission, was approved.

3. The chairman of the Mental Health Committee was designated as the Society's official delegate to the A.M.A. congress on Mental

continued on page 580

Stelazine® will stop anxiety—but not your patient!
brand of trifluoperazine

To be truly useful in your office patients, an ataractic agent must not only relieve anxiety; it must also leave these patients sufficiently alert to engage in their normal activities.

'Stelazine' is such an agent. Its ability to relieve anxiety without producing appreciable sedation has been established in thousands of patients and documented by many published reports. Typical is the finding of Kolodny,[1] who concluded that the primary advantage of 'Stelazine' over many other tranquilizers seems to be "its ability to relieve symptoms of anxiety without undue interference with alertness."

When you wish to relieve anxiety, yet encourage the patient to engage in his normal activities, consider 'Stelazine'.

1. Kolodny, A.L.: Dis. Nerv. System *22*:151 (Mar.) 1961.

For prescribing information, please see *PDR* or available literature.

Smith Kline & French Laboratories, Philadelphia
leaders in psychopharmaceutical research

SK&F



HOUSE OF DELEGATES

continued from page 578

Health to be held in Chicago.

4. Acknowledgment was made of a $120 contribution by the Woman's Auxiliary to the Benevolence Fund of the Society.

5. Doctor Earl F. Kelly of Pawtucket was nominated as the Society's representative on a state advisory committee on the accreditation of nursing homes.

6. Doctor Richard Kraemer, chairman of the Society's committee on aging, was named as official delegate to the A.M.A. regional conference on Aging to be held in Buffalo, New York, November 1, 2 and 3.

7. The Council ruled that the sesquicentennial assessment assessed late in 1961 must be paid by every member who wishes to retain his Society membership in good standing, by December 1, 1962.

8. The secretary was instructed to notify Physicians Service of the suggested fee changes approved by the House of Delegates at its meeting on April 30, 1962.

9. A contribution was authorized of $100 to the Rhode Island League of Nursing towards the cost of a survey it will conduct on nursing needs and resources in Rhode Island.

10. A press release, as well as information to the members of the Society regarding the possibility of an influenza epidemic in the winter season of 1962-63 was authorized.

11. Approval was given of the president's appointment of Doctor George Farrell as trustee-at-large to the Board of Trustees of the Rhode Island Medical Society Library building for the year 1963.

12. Doctors Samuel Adelson, Arthur E. Hardy, and Francis B. Sargent were named official delegates from the Society to the Council of the New England State Medical Societies.

13. The Board of Trustees of the Medical Library was authorized to proceed with recommended improvements to the Reading Room of the Library building.

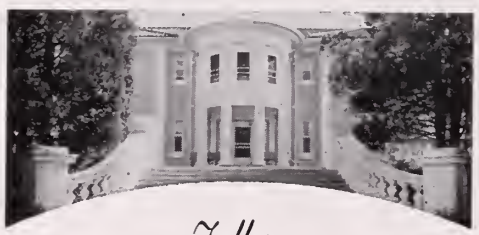
14. The treasurer was authorized to approve changes in some of the investments of the Society as recommended by the Trust Department of the Industrial National Bank.

15. A report of a special committee to consider the possible expansion of the executive office staff was reviewed, and appropriation was made for additional secretarial assistance for the executive officer.

16. The budget for 1963 was reviewed and approved for submission to the House.

17. The secretary was authorized to express to the proper Navy authorities the Society's appreciation of the outstanding services rendered by Captain Joseph Yon who is being transferred from his post as Senior Medical Officer of the Newport Naval Hospital.

MICHAEL DIMAIO, M.D., *Secretary*



Fuller

Memorial Sanitarium

Located on Rt. 1

South Attleboro, Massachusetts

A modern non-profit hospital for the care and treatment of nervous and emotional disorders as well as long term geriatric problems.

Physical, neurological, psychiatric and psychological examinations.

Modern recognized psychiatric therapies.

A pleasant homelike atmosphere in a beautiful and conveniently located institution.

L. A. Senseman, M.D., F.A.P.A., Medical Director
Edwin Dunlop, M.D. Michael G. Touloumtzis, M.A.
Oliver S. Lindberg, M.D. William H. Dunn, M.S.W.
W. H. Lesovsky, M.D., Ph.D.

Referred patients are seen daily (except Saturdays) 9-12 A.M., and by appointment.
R. I. Blue Cross Benefits Tel. Southgate 1-8500

Special Rates for Long-Term Care

SESQUICENTENNIAL COMMITTEE

The successful Scientific Assembly at the Brown University gymnasium in May, following the outstanding public health fair at the Cranston Street Armory in April, climaxed the work of the Sesquicentennial Committee of the Society.

The committee's main concern was the Exposition of Health Progress which drew the largest crowd to attend any event at the Armory within a one week period. Approximately 82,500 persons visited the Exposition and benefited by the lectures given by physicians and allied medical personnel, and by the excellent health displays that were exhibited.

There is no exact method of determining the full impact of the Health Fair upon the general public. We strongly believe, however, that it constituted one of the finest community services that has ever been staged in this state by any organization.

Veteran health fair officials, and American Medical Association experts, deemed the Rhode Island Exposition one of the best staged in their experience.

The Committee has expressed its appreciation publicly and by direct mailings to all those who aided in making the Sesquicentennial's feature event the success that it was.

Financially the Society has expended only $2,000 more than its anticipated income to stage the Exposition. A complete financial report is appended to this report.

THOMAS PERRY, JR., M.D., *Chairman*

REPORT OF THE TREASURER

Sesquicentennial

The cost of the Exposition of Health Progress has been approximately $2,000 more than was anticipated through the special assessment and the donations from companies that sponsored exhibits at the Health Fair. A financial statement is appended to the report from the Sesquicentennial Committee.

Invested Funds

Appended is a Summary of Account by the Trust Department of the Industrial National Bank on the invested holdings of the Society as of June 8, 1962.

The Trust Department has recently recommended, and the Council has approved, that the Society sell 50 shares of American Home Products and 30 shares of Sinclair Oil, and buy with the moneys thus secured $3,000 in medium term bonds.

A summary of the invested holdings of the Society is appended to this report.

Budget for 1963

In accordance with the by-laws a budget for next year is submitted which is predicated on past experience, and which allows for additional expenditures to provide for necessary improvements to the Library building, for subsidy to the Medical Journal which is faced with an increasing loss of advertising revenue, and for additional secretarial assistance to the executive officer.

J. M. BEARDSLEY, M.D., *Treasurer*

DISASTER COMMITTEE

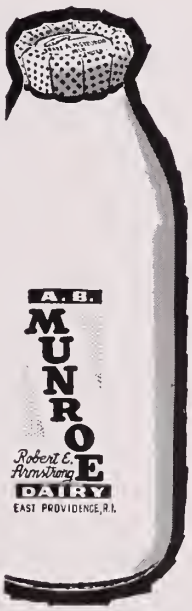
The Committee on Disaster held one meeting during the summer to discuss procedures to be followed regarding community action to plan for a disaster. The highlights of the national conference on preparedness for catastrophes staged by the American Medical Association were reviewed by Doctor Hilary J. Connor who represented Rhode Island at the conference.

The utilization of 100,000 doses of tetanus vaccine available through the state health department for a possible wide scale immunization program was

continued on next page

AS CLEAN
AS MODERN
DAIRY SCIENCE
CAN MAKE IT...





The A. B. Munroe Dairy Laboratory, where milk is subjected to constant testing, using the most modern methods of milk analysis.

Through every step in processing, from the immaculate receiving room to pasteurizing and homogenizing, on through bottling and refrigeration, the A. B. Munroe Dairy observes the strictest standards of dairy hygiene. The spotless surroundings and rigid quality control are so designed that all A. B. Munroe Dairy products that reach your table are as fresh, wholesome and pure as modern science can make them.

A. B. MUNROE DAIRY, INC.
151 Brow Street, East Providence, Rhode Island

Call GE 8-4450
for Home Delivery

discussed by the Committee who agreed that the first step should be taken with a letter sent from the Health Department to all the physicians in the state notifying them that they may secure the vaccine free of charge from the Health Department to use for the immunization of their patients. Subsequent to this approach, it was suggested that the committee might co-ordinate its activities with the Child-School Health Committee should it attempt a state-wide mass immunization for polio in 1963, utilizing the Sabin vaccine. It was thought that such a plan might be attempted as has been carried out in other major communities publicizing the importance of tetanus immunization, and the immunization carried out for all who would accept it.

Medical Self-Help Program

The Committee discussed the pros and cons of the Medical Self-Help Program and there was general concern regarding the difficulty of reaching large segments of the population with this educational plan.

It was agreed that the chairman should again urge the district medical societies to work with the local civil defense personnel, possibly acting as sponsors of community plans to educate the public in the self-help medical plan.

The members also felt that the chairman might recommend that the state civil defense organization explore the possibility of using television both to explain and also possibly to demonstrate the entire medical self-help program to the general public.

Doctor Hanley reported that television had been used in Washington, D.C., with the presentations given by members of the teaching staff of George Washington University Medical School.

The Wagner Plan

Copy of reports by Carruth J. Wagner, M.D., chief, Division of Health Mobilization, office of the surgeon general, Public Health Service, Department of Health, Education and Welfare, on *Developing and Implementing a Co-ordinated Community Health Plan for Disaster Preparedness*, and *Organization and Functions of a Local Emergency Health Service*, supplied by Doctor Connor, were distributed to the members of the committee for discussion. Doctor Wagner's reports were given at the 10th Annual National Conference on Disaster Medical Care held in Chicago on June 23.

Doctor Hanley stated these reports were for information purposes only and further information was expected at a later date relative to the implementation of some of the suggestions advanced by Doctor Wagner.

Respectfully submitted,

FRANCIS E. HANLEY, M.D., *Chairman*

ORAL POLIOMYELITIS PROGRAM

In accordance with the request of the Council of the Rhode Island Medical Society that the Mass Immunization Committee and the Child-School Health Committee formulate a plan to carry out a statewide program of mass immunization with the Sabin oral vaccine, preferably in the early part of 1963, and that the proposed plan be submitted to the House of Delegates at its September meeting, the following joint report is submitted by the chairmen of these two committees:

Oral Polio Program for Rhode Island

Several major communities in the nation have already conducted voluntary mass polio immunization programs utilizing oral vaccines. Therefore the pattern of successful operation of such an immunization plan on a major scale has been tested, and the experiences have been made available to the committees of the Society.

A brief outline of what would be attempted follows:

1. A statewide immunization program would be staged on three Sundays: January 27, 1963 — for Type I; March 17, 1963 — for Type III, and April 28, 1963 — for Type II.

2. Every resident of Rhode Island and its environs would be eligible.

3. The program would be sponsored jointly by the Rhode Island Medical Society and the Rhode Island State Department of Health. The members of the Society would be asked to supervise each of the immunization centers, and to encourage their patients and other fellow citizens to be immunized. The Society would guarantee the costs of operation of the program.

The State Health Department would supervise the entire logistic phase of the plan, would utilize all its personnel, and would aid in co-ordinating the plan over-all.

4. The immunization centers would be 34 public junior high schools and 32 senior high schools throughout the state, and the Cranston Street Armory in Providence. The centers would be open from 10:00 A.M. until 6:00 P.M. on the respective Sundays.

5. The estimated total attendance at the centers is 600,000 for the first Sunday, and 500,000 for each of the succeeding two days of immunization.

6. No fee would be charged, but a 25¢ donation (minimum) would be suggested to pay for the vaccine and program operation costs.

Experience in other areas has indicated that the program on this basis will be financially successful. Any surplus over operating costs would be donated to such charities as the Rhode Island Medical Society might determine.

* * *

Your committee chairmen, and Doctor James Bowes, medical director of the Communicable Disease Division of the State Health Department, have met with representatives of the three major pharmaceutical companies that manufacture oral vaccine for polio. All three companies are prepared to provide technical and public relations assistance in connection with the mass immunization plan.

The State Health Department has already made estimates on operations costs, and various phases of the mobilization of personnel for such a major task.

We are fully conscious of the fact that this undertaking will call for a tremendous all-out effort by every one to achieve the success necessary to eliminate polio from Rhode Island. We would confidently count on support from every community agency and industry, from all the communications media, from the clergy, the teaching profession, and particularly from the profession and all allied to the various phases concerned with the healing art.

We envision the need for skilled public relations counsel, for a statewide advertising campaign, and for the necessary help to put across the campaign. It is not a program for amateurs to attempt. The experience in other communities where the plan has been carried out has been that sufficient contributions are received to finance all such necessary services in addition to the cost of the vaccine. An approximate estimate would be $75,000 for each of the Sunday programs we contemplate.

Your chairmen have been concerned by the news stories within the recent weeks of the adverse experience in Canada, and of some paralytic cases in the United States, presumably caused by Type III vaccine. We have noted the decision of the surgeon general's advisory committee which stated in part that

> "The Committee believes that there is sufficient epidemiological evidence to indicate at least some of these cases have been caused by Type III vaccines. The level of this risk can only be approximated, but clearly is within the range of less than one case per million doses. Since the cases have been concentrated among adults, the risk to this is great whereas the risk to children is exceedingly slight or practically non-existent. The Committee therefore recommends that the use of Type III in mass campaigns be limited to preschool and school age children. Plans for mass programs using Type I and Type II in all age groups should continue. . . ."

On the basis of this recommendation your committee chairmen, and the State Health Department, are of the opinion that our proposed mass immunization should proceed as contemplated.

At this time we submit the entire proposal as outlined above, to the House of Delegates for its

continued on next page

LIFE INSURANCE or DEATH INSURANCE?

SOME Medical men need DEATH Insurance ONLY.

Others need accumulating, guaranteed dollar values to meet their LIVING needs in the future — DEPRESSION — EMERGENCY — RETIREMENT, etc.

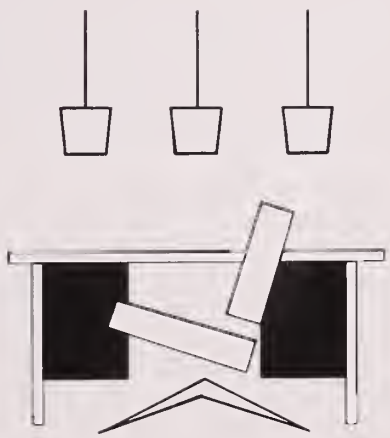
In any event, our new "CHEAPER-THAN-TERM" DEATH INSURANCE is the first step in the right direction!

Don't make any important changes in your Life Insurance or Estate plans without investigating "CHEAPER-THAN-TERM"!

For further information about this sensational new development in DEATH INSURANCE, write or phone:

ROLAND A. DEROSIER
54 Custom House Street
Providence 3, Rhode Island
TE 1-4833

Attractive & Functional Offices
by BENÉ & CO., INC.



Designers & Suppliers of Offices
150 Dorrance Street • Providence 3, R. I. • GAspee 1-5228

consideration. If the mass immunization plan is approved, we are prepared to proceed promptly with all the necessary preliminary work to prepare for the first Oral Polio Sunday the end of January.

Respectfully submitted,
JOHN T. BARRETT, M.D., *Chairman*
Mass Immunization Committee
RUDOLPH A. JAWORSKI, M.D., *Chairman*
Child-School Health Committee

* * *

MEDIATION COMMITTEE

The Committee on Mediation has had only two meetings since its last report. Only four cases of grievance were processed and two potential suits were discussed. I am glad to report this decrease in the work of the committee.

FRANCIS B. SARGENT, M.D., *Chairman*

COMMITTEE ON MENTAL HEALTH

Your Committee on Mental Health has been delegated the function of effecting better Mental Health in the community and to effect humanitarian and sophisticated medical care of the mentally ill. One of the objectives of your Committee has been to work toward a position of Steersmanship in these two aspects of medicine. Basic to this conception is the premise that the profession of medicine through its sense of proportion, through its seeking for knowledge, through its studies of fundamentals is best suited for this leadership.

The Council on Mental Health of the American Medical Association will convene a National Congress on Mental Illness and Health in Chicago on October 4, 5, and 6, 1962. This conference is seen from the perspective of coming to aid the Rhode Island Medical Society in achieving professional leadership within the scope of mental health and mental illness. Your Committee was asked by the Council on Mental Health to invite leaders in the community to attend this conference, to set up a steering committee to guide the Rhode Island Delegation in the following direction: Come back with specific recommendations, tailored to our local conditions, on matters that the delegation considers have high priority in effecting better mental health in the community and excellence in treatment of the mentally ill. As of this moment, it would appear some 18 or 20 people from different aspects of community life will attend the conference in Chicago. Your committee notes with regret that members of the Rhode Island Medical Society who limit their practice to neurology and psychiatry are the only physicians thus far who intend to participate in the American Medical Association's Conference on Mental Illness and Health. Your Committee can rationalize this situation. We would prefer to face up to the fact that we cannot achieve our objective while unsophisticated, traditionally taboo attitudes prevail around those aspects of medicine which pertain to mental health and illness. It is true that within the range of the past 30 years both the profession and the public have come to take a more empathetic attitude toward mental health and mental illness. It is true that in keeping with the trend toward specialization that many members are so dedicated to their particular aspect of medicine that there is just not enough time. Your Committee wants this report to stimulate contemplation and reflection on this eve of this American Medical Association Conference. We want this contemplation and reflection to upgrade each and every member's level of sophistication with respect to human beings who are overwhelmed by their problems in living. Our particular profession, in company with other professions, finds itself in the position of being a scapegoat. There is some truth in the point of view that the profession of medicine has momentarily lost sight of the humanitarian approach to its patient. This is to advocate a high priority among the complexity of our consideration to the fact that the patient is a human being.

The Committee on Mental Health presents the following resolution for adoption:

Resolved — That the House of Delegates sees the meaningfulness of the American Medical Association's emphasis on Mental Illness and Health.

The House of Delegates acknowledge that there is an intrinsic shortsightedness inherent in the meaningful trend toward specialization. This shortsightedness should be offset by a better sense of proportion. Such could be achieved by a more sophisticated approach to Mental Health and Illness by each and every member of the Society. A more sophisticated approach would result in the profession of medicine having steersmanship in a field which the State of Rhode Island under the medical practices act makes the responsibility of licensed physicians.

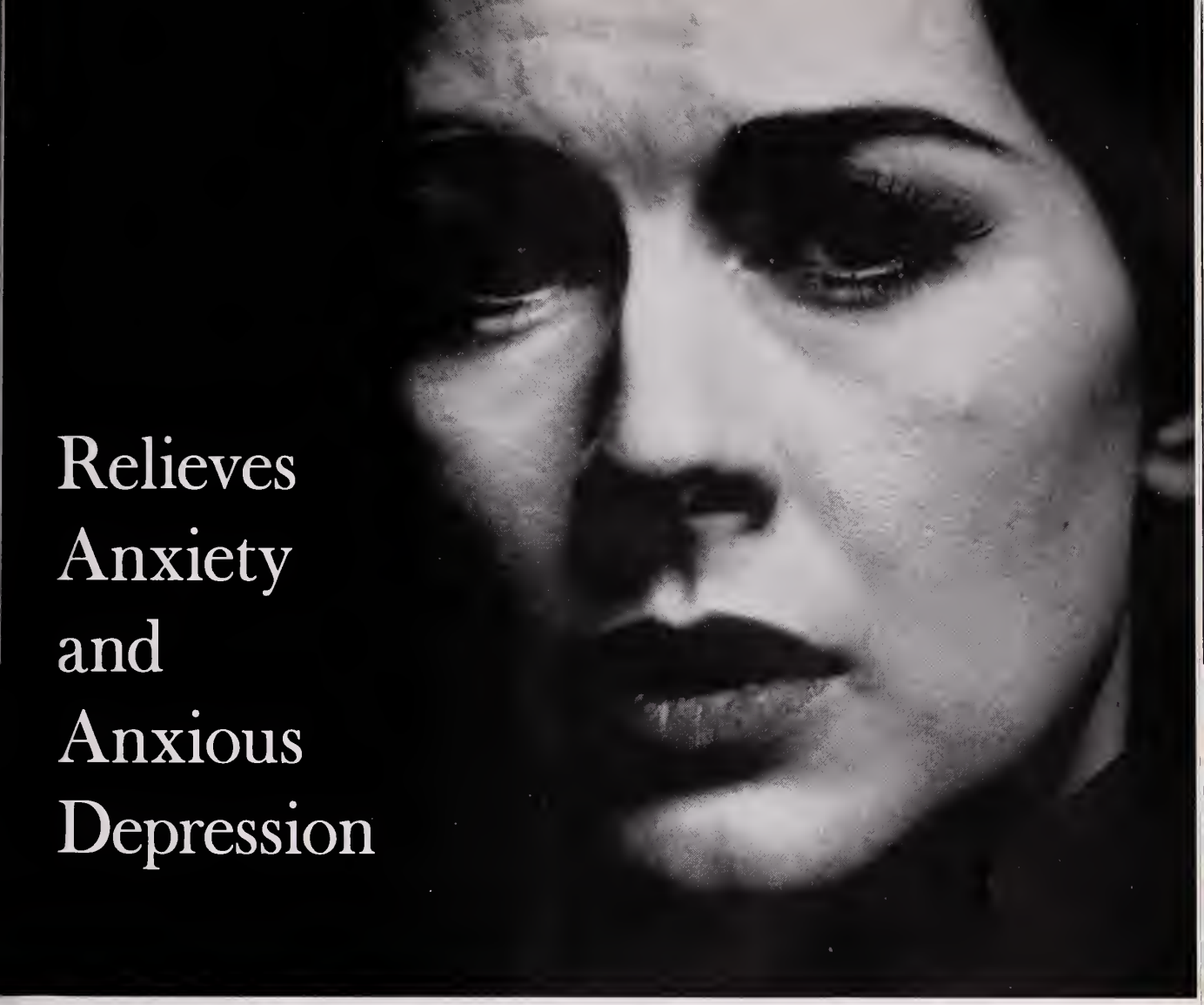
Should there be physicians who have now decided they wish to attend the American Medical Association's National Congress on Mental Illness and Health, your Committee will be happy to assist them in making the necessary arrangements.

HAROLD W. WILLIAMS, M.D., *Chairman*

REPORT OF COMMITTEE ON MEDICAL ASPECTS OF SPORTS

The Committee on the Medical Aspects of Sports of the Rhode Island Medical Society has the pleasure of reporting that it held its second annual conference on Monday, September 10, 1962, in the Carmichael Auditorium of the Psychology Building of Brown University. The meeting consisted of an afternoon and evening session. Approximately 100 athletic department personnel of the secondary schools of Rhode Island attended. The program

continued on page 586



Relieves Anxiety and Anxious Depression

The outstanding effectiveness and record of safety with which Miltown relieves anxiety and anxious depression—the type of depression in which either tension or nervousness or insomnia is a prominent symptom — has been clinically authenticated time and again during the past seven years. This, undoubtedly, is one reason why physicians still prescribe meprobamate more often than any other tranquilizer in the world.

Miltown®

meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50. Also as MEPROTABS® — 400 mg. *unmarked*, coated tablets; and in *sustained-release* capsules as MEPROSPAN®-400 and MEPROSPAN®-200 (containing respectively 400 mg. and 200 mg. meprobamate).

WALLACE LABORATORIES / *Cranbury, N. J.*

Clinically proven in over 750 published studies

1. Acts dependably — without causing ataxia or altering sexual function
2. Does not produce Parkinson-like symptoms or liver damage
3. Does not muddle the mind or impair physical activity

CM-7381

HOUSE OF DELEGATES

continued from page 584

opened at 1:30 P.M. and closed at about 9:00 P.M. The subjects discussed were as follows:

1. *Training for Injury Prevention* from the College Standpoint by Paul F. Cieurzo, Assistant Director of Athletics, University of Rhode Island. From the High School Standpoint by Ralph J. Cordisco, Director of Athletics and Physical Education, Haverstraw-Stony Point Central School District, Haverstraw, N.Y.

2. *Field Diagnosis*, a Panel Discussion by Daniel F. Hanley, M.D., of Brunswick, Maine, Director of Student Health Services, Bowdoin College, and Physician to the U.S. Olympic Teams in Rome, Italy, in 1960; G. Edward Crane, M.D., Athletic Surgeon, Brown University; and Joseph E. Donahue, M.D., Assistant Director, Student Health Services, Providence College.

3. *The Helmet and Face Guard, and Head Injuries* by Thomas B. Quigley, M.D., of Boston, Massachusetts, Chairman, Committee on Medical Aspects of Sports, the American Medical Association; Assistant Clinical Professor of Surgery, Harvard Medical School; Surgeon, Peter Bent Brigham Hospital; Surgeon, Harvard University Health Services.

4. *Injuries Due to Poorly Fitted Equipment* by Allan J. Ryan, M.D., of Meriden, Conn., member, Committee on Medical Aspects of Sports, the American Medical Association; president-elect, American College of Sports Medicine.

5. *Taping for Protection and Prevention of Injuries* by Joseph Romo, head athletic trainer, Brown University, and Richard Cole, Associate Professor of Physical Education and Athletic Therapist, University of Rhode Island.

After a very excellent supper in the refectory of Brown University, the meeting reconvened in the president's dining hall at the refectory to hear a very excellent talk on *Fatigue as it Affects the High School Athlete* by Dr. Peter V. Karpovich, research professor, Physiology, Springfield College, Springfield, Massachusetts.

The various talks were well received. One of the features of the conference was the participation of the audience with questions being asked by them and answered by the speakers.

The audience expressed a desire to have the conference continued on a yearly basis.

Respectfully submitted,

A. A. SAVASTANO, M.D., *Chairman*

COMMITTEE ON MEDICAL ECONOMICS

At a meeting of the Board of Directors of Physicians Service, held on March 19, 1962, the following action was taken:

A. "The Board voted to refer the A.M.A.-Blue Shield National Senior Citizen Program to the House of Delegates of the Rhode Island Medical Society with approval in principle by the Board of Directors of the objectives of this program."

At a meeting of the Board of Directors of Physicians Service, held on April 23, 1962, the following action was taken:

B. "The Board of Directors of Physicians Service voted to adopt the principle of in-hospital medical care on a Service basis under supplemental plans comparable to present plans A and B, with the proposed fee schedule to provide under one supplementary plan $10.00 for the first day, $7.00 for the second day and $4.00 per day thereafter to a maximum of $260.00, and and under the other supplementary plan $15.00 for the first day, $10.00 for the second day and $5.00 per day thereafter to a maximum of $465.00."

In-hospital Medical Benefits on Service Basis

The recommendation of April 23, 1962, concerning in-hospital medical care on a Service basis for *all* participants in the Physicians Service Program was referred to the Committee on Medical Economics for their study. Because of the Health Fair and the Annual Meeting, the first available date for the committee meeting was May 21, 1962. Present at this meeting were eight of the nine committee members and Mr. Clapp and Mr. Perry of Physicians Service. Both recommendations of the Board of Physicians Service mentioned above were considered as well as the resolution of the Pawtucket Medical Association that the Rhode Island Medical Society evaluate and consider the newly adopted policy of Massachusetts Blue Shield which renders full coverage for medical illness of a severe and critical nature.

After prolonged discussion, the committee voted 7 to 1 against any Physicians Service plan which was based on in-hospital medical care on a *Service* basis. Because of the importance of this issue, the committee voted unanimously that the entire membership of the Society be polled as to its present desires as to Service versus Indemnity benefits for medical care.

The poll to the members made the following inquiry:

Service or Indemnity?

In view of the fact that possible future developments of Physicians Service hinge on whether or not in-hospital medical benefits shall be on a service basis, or continue on an indemnity basis, the Committee on Medical Economics of the Rhode Island Medical Society is polling the entire Society membership on this important issue.

Service benefits means that the physician will

continued on page 588

AN AMES CLINIQUICK®
CLINICAL BRIEFS FOR MODERN PRACTICE

WHY TEST URINE ROUTINELY FOR PROTEIN ?

In a recent series of 278 diabetic patients, 34.2 per cent (95) had proteinuria. Of this group, almost 3 out of 5 had previously unrecognized renal disease, usually asymptomatic and untreated.[1] Proteinuria may give valuable warning not only of infectious and other renal disorders, but also of degenerative diabetic nephropathy.[2]

With URISTIX Reagent Strips, testing for proteinuria *and* glucosuria may be conveniently done at the same time. URISTIX is "... reliable for routine clinical use."[1] It will not give false-positive protein reactions with oral hypoglycemic agent metabolites. URISTIX is simple for patients to use at home and is timesaving for technicians.[1]

References: (1) Moss, J. M.; Schreiner, G. E., and Sweeney, V.: M. Times *89*:12 (Jan.) 1961. (2) El Mahallawy, M., and Sabour, M. S.: J.A.M.A. *173*:1783 (Aug. 20) 1960.

for broader day-to-day protection of the diabetic patient

DIP AND READ

uristix®

urine protein • glucose

AMES COMPANY, INC Elkhart • Indiana Toronto • Canada

1 dip . . . 10 seconds . . . 2 readings

available: URISTIX Reagent Strips, bottles of 125

20062

COMMITTEE ON MEDICAL ECONOMICS

continued from page 586

receive stated fees for the entire period of hospitalization and he may not submit any additional charges for the services rendered.

Indemnity benefits means that the physician receives a per diem fee towards his total charges for the medical services rendered.

Results of Poll

As of July 2, 1962, 631 replies from 980 members have been received and analyzed.

1. In favor of in-hospital care on Service basis	171
2. In favor of in-hospital care on Indemnity basis	304
3. No opinion	80
4. Miscellaneous	16

It is quite apparent that at this date with over 64 per cent replies received that the Rhode Island Medical Society is clearly against Service benefits for in-hospital medical care by over a 2 to 1 vote. This is a reversal of the poll conducted by Physicians Service in 1960.

Why the reversal of opinion? It would only be fair to speculate that during the past two years much has occurred to stimulate the thinking of the Rhode Island physician. He has witnessed the spectacle of the director of the State Department of Business Regulation conducting an open hearing during which labor leaders used the entire profession as whipping boys with unsubstantiated charges. He has seen the legislature successfully include the podiatrists in the Physicians Service program. He has seen the legislature pass a bill that would include the chiropractors in our Plan, only to be turned down by a last minute veto by Governor Notte who, in his statement of veto, chose to make derogatory remarks about Rhode Island physicians.

He has seen the Blue Shield in the neighboring state of Massachusetts apply for increases in its fee schedules and have the request turned down by the state insurance commissioner and the superior court.

The medical man has digested these events and apparently has concluded that he does not wish to be in the position of the surgeon and anesthetist who must accept fees on a service basis.

Revision of Blue Shield Fee Schedule

Revision of the surgical fee schedule has been prepared by this Committee. It will undoubtedly require some increase in the premium of Physicians Service. This increase must be approved by the director of Business Regulation, and the surgeons of Rhode Island have reason to be concerned with the fate of these revisions at the hands of the present director of Business Regulation.

The committee, however, has noted with interest that the supreme court of Massachusetts has reversed the insurance commissioner and superior court rulings in that state relative to the Blue Shield action mentioned above. In its ruling the supreme court stated in part:

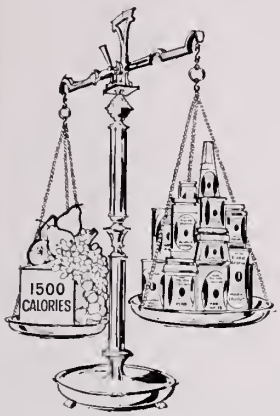
> "In determining whether rates are inadequate, excessive or unfairly discriminatory the Commissioner must apply criteria which are relevant to the purpose and effect of the statute.
>
> "We agree with the petitioners that prevailing charges in the community for like services are important measures. The fees of physicians apart from any plan, and their fees under other plans, are relevant. So are increased costs and expenses of physicians subsequent to the date of approval of existing fee schedules as well as increases in costs of living indices. Some weight may be given to the studies of the Blue Shield fee committee composed of representatives of each of the subspecialties in medicine and surgery, and to their method of formulating the schedule, and also to the views of such a group as the Council of the Massachusetts Medical Society.
>
> "We agree with the petitioners that the purpose of 'low cost' expressed in the preamble to the statute, does not require that the fees be fixed at below prevailing rates . . .
>
> ". . . The record shows that there has been no substantial change in surgical fees since 1950, that the schedule is consistent with the Medical Schedule of fees by which the Federal Government pays Massachusetts physicians for their services to dependent military personnel, and with the Baker Memorial Hospital schedule used by the Massachusetts General Hospital, and with the schedule of the Rhode Island Medical Society's Physicians Service Master Schedule of Indemnities, and with the larger Blue Shield plans throughout the country. None of the rates exceeds those generally charged by participating physicians, and in a number of instances are below such changes. The cost of medical services has increased since 1950 as has the cost of living. The proposed increases average about ten per cent. . . ."

* * *

The criteria cited in this court opinion parallels that which we have attempted to follow in reviewing the fees of our present "A" and "B" programs of Physicians Service.

We believe that Rhode Island physicians are anxious to continue to render services to their patients on a voluntary basis for fair and reasonable fees. It is regrettable that third party agencies have increasingly become control factors that interfere

concluded on page 600



How to get patients to follow your directions for weight control...easily

60 DELICIOUS FOODS THAT CUT CALORIES, FAT AND CARBOHYDRATES!

How often do you sit across the desk from a patient whose problem is overweight, and wonder whether the directions you give for diet will be followed accurately—or at all?

A pleasant and efficient solution to this problem is to recommend the new Mott's Figure Control Foods. This line of over 60 different items has been developed through the latest scientific knowledge in the field of nutrition—and provides foods lower in calories by an average of 50%. Figure Control Foods take the guesswork out of menu-planning. Calorie cutting can be made pleasant and accurate, while eating normal-size portions of the kinds of food people enjoy every day at breakfast, lunch and dinner.

Low carbohydrate, low fat: Meat products have most of the hard fats removed (these are the saturated type) in a way that cannot be done at home. Sauces and dressings are prepared with a high proportion of non-fat milk solids, vegetable colloids; all are delicious and appetizing. Fruits, juices, desserts and sauces are prepared with non-caloric sweetener—natural fruit values are intact.

The carbohydrate, protein and fat content appears on each label, along with calorie counts. Useful for diabetics, too.

Easy medical tool for doctors: No possible dangerous side effects, not even temporary dislocation of meal patterns. Figure Control Foods in supermarkets include: Soups, Meats, Poultry, Sauces, Salad Dressings, Preserves, Syrup, Fruits, Drinks, Desserts, Sweeteners.

New Mott's Figure Control® Foods offer Good Eating at Half the Usual Calories

	Quantity	Figure Control Calories	"Regular" Food Calories
Apple-Grape Drink	½ cup	20	52
Five-Fruit Juice Breakfast Drink	½ cup	20	52
Braised Beef and Vegetables	6½ oz.	184	380
Meat Balls in Brown Gravy	3½ oz.	84	280
Chopped Chicken Livers	1 oz.	31	100
Chicken a la King	3 oz.	72	230
French Style Dressing	1 tbsp.	10½	60
Brown Gravy	1 tbsp.	7	21

	Quantity	Figure Control Calories	"Regular" Food Calories
Applesauce	½ cup	48	90
Fruit Cocktail	½ cup	44	90
Cherry Pie Filling	1 oz.	20	60
Chocolate Topping	1 tbsp.	8	63
Preserves (Peach, Strawberry)	1 tbsp.	9	55
"Maplette" Syrup	1 tbsp.	9	55
Liquid or Powder Sweetener	(to equal 1 tbsp. of sugar)	0	16



Complete menus, recipes, calorie chart available for professional distribution, with weight control guides you can distribute with confidence: all menus meet N.R.C. Recommended Daily Allowances. **Use this handy order form:**

FIGURE CONTROL FOODS
Duffy-Mott Company
370 Lexington Avenue
New York 17, New York

Please send____free copies of YOUR WEIGHT CONTROL PLAN for use with patients.

Dr._____

Address:_____

City:_____ Zone:____ State:_____

ON THE MEDICAL LIBRARY BOOKSHELVES

GIFTS

Concluded from October Issue

From Herbert F. Hager, M.D. — A MANUAL OF THE PRACTICE OF MEDICINE. Prepared Especially for Students. 8th ed., repr. Phil., 1910.

From Arthur E. Martin, M.D. — RECENT ADVANCES IN NEUROLOGY AND NEUROPSYCHIATRY by W. Russell Brain and E. B. Strauss. 5th ed. The Blakiston Co., Phil., 1946.

— SURGERY OF THE HAND by Sterling Bunnell, M.D. J. B. Lippincott Co., Phil., 1944.

— DISEASES OF THE KNEE. Management in Medicine and Surgery by Anthony F. DePalma. J. B. Lippincott Co., Phil., 1954.

— REST AND PAIN by John Hilton. Edited by E. W. Walls and Elliot E. Philipp in Collaboration with H. J. B. Atkins. J. B. Lippincott Co., Phil., 1950.

— FRACTURES AND JOINT INJURIES by Reginald Watson-Jones. 3rd ed. 2 vols. Williams & Wilkins Co., Balt., 1944.

— BONE AND JOINT DISEASES by J. Vernon Luck. Charles C. Thomas, Publisher, Springfield, Ill., 1950.

— THE TRAUMATIC DEFORMITIES AND DISABILITIES OF THE UPPER EXTREMITY by Arthur Steindler in Collaboration with John Louis Marxer. Charles C. Thomas, Publisher, Springfield, Ill., 1946.

From Arnold Porter, M.D. — THE MODERN THEORY AND PRACTICE OF PHYSIC. Wherein the Antecedent Causes of Diseases; the Rise of the Most Usual Symptoms Incident to Them; and the True Methods of Cure are Explain'd . . . by Browne Langrish. 2nd ed. Lond., 1738.

— THE PHILOSOPHICAL TRANSACTIONS (From the Year 1719, to the Year 1733) Abridged, and Disposed Under General Heads by Dr. John Eames and John Martyn. v. VII, Lond., 1734.

— (THE PRACTICE OF PHYSIC. In Seventeen Books by Lazarus Riverius. Lond., 1678). Title page and other pages missing.

From Francesco Ronchese, M.D. — ATTI DEL III° CONVEGNO DELLA MARCA PER LA STORIA DELLA MEDICINA. Sotto La Presidenza Onoraria di Adalberto Pazzini. Presidente del Comitato Promotore, Mario Santoro. Fermo, Sede dell'Antica Universita 24-25-26 Aprile 1959.

—LA PHYSIOTHERAPIE DES PRURITS. Imprimerie Thomas, Editeur. Limoges, 1928. Travail du Laboratoire des Agents Physiques du Professeur Jeanselme.

— THE GRANITES OF VERMONT by T. Nelson Dale. U.S. Government Printing Office, Wash., 1909.

— AN EXPERIMENT IN MEDICINE. The First Twenty Years of the Pratt Clinic and the New England Center Hospital of Boston by Joseph E. Garland. Riverside Press, Cambridge, 1960.

— IL METICCIATO DI GUERRA E ALTRI CASI by Luigi Gedda, Angelo Serio and Adriana Mercuri. Prefazione del Prof. R. Ruggles Gates. Edizioni dell'Instituto Gregorio Mendel, Roma, 1960.

— DOCTORS PHILATELIC by Oscar Gottfried. Published by the American Physician, Inc., N.Y., 1954, and Sup. #1, January 1958.

— MANUEL PRATIQUE DE PROCTOLOGIE. Clinique et Therapeutique des Maladies de l'Anus et du Rectum by René B. Henry and G. B. E. Simonetti. J. B. Bailliere et Fils, Par., 1954.

— FOLK MEDICINE by D. C. Jarvis, M.D. Henry Holt & Co., N.Y., 1958.

— MANUAL OF HUMAN MICROSCOPICAL ANATOMY by Albert von Kölliker. Translated by George Busk and Thomas Huxley. Edited, with Notes and Additions, by Jacob M. DaCosta. Phil., 1854.

— THE ESOPHAGUS AND PHARYNX IN ACTION. A Study of Structure in Relation to Function by William Lerche, M.D. Charles C. Thomas, Publisher, Springfield, Ill., 1950.

— RECURRENT MALADIES IN SCHOLARLY WRITING by Eugene S. McCartney. University of Michigan Press, Ann Arbor, 1955.

— GRANITE CUTTING. An Analysis of the Granite Cutter's Trade . . . by G. A. McGarvey and H. H. Sherman. U.S. Government Printing Office, Wash., 1938.

— LA FOTOTERAPIA. Basi Scientifiche — Apparecchi — Applicazioni by Cesare Patrizi. L.

Cappelli, Bologna, Editore. Trieste, 1924. Collezione Medica di Attualita Scientifiche, ser. 1, #7.

—L'EMOINNESTO INTRAMUSCOLARE E LE RADIAZIONI VITALI NELLA VECCHIAIA E NELL'ESAURIMENTO by Giocondo Protti. Prefazione di Benedetto Schiassi. Hoepli, Milano, 1931.

—ELEMENTS OF ANATOMY by Jones Quain. Edited by William Sharpey, Allen Thomson and Edward A. Schäfer. 8th ed. v. 1. Lond., 1876.

—TRAITÉ DES MALADIES QU'IL EST DANGEREUX DE GUÉRIR . . . by Dominique Raymond. 2 vols. Chez F. B. Merande, Imprimeur, Avignon, 1757.

—BRAZILIAN MEDICAL CONTRIBUTIONS. Edited by Leonido Ribeiro. Livraria Jose Olympio, Editora. Rio de Janeiro, 1939.

—A PRACTICAL ESSAY ON TYPHOUS FEVER by Nathan Smith. N.Y., 1824.

From David D. Rutstein, M.D.—SIXTY-EIGHTH ANNUAL REPORT UPON THE BIRTHS, MARRIAGES AND DEATHS IN THE CITY OF PROVIDENCE for the Year 1922 by Charles V. Chapin, M.D.

From Mrs. H. Frederick Stephens—HEALTH MOBILIZATION COURSE MANUAL. U.S. Department of Health, Education, and Welfare, Public Health Service Under Assignment by the Office of Civil and Defense Mobilization. Health Services Aspect of Health Mobilization. Wash., n.d.

From Joseph I. Waring, M.D.—EXCERPTS FROM THE MINUTES OF THE MEDICAL SOCIETY OF SOUTH CAROLINA, 1789-1820.

—EXCERPTS FROM THE MINUTE BOOK OF THE MEDICAL SOCIETY OF SOUTH CAROLINA, 1820-1908. v. 2. Arranged by Joseph I. Waring, M.D.

PEDIATRICS AS A CAREER. American Academy of Pediatrics, Evanston, Ill., 1962. Gift of the Academy.

AMERICAN COLLEGE OF SURGEONS DIRECTORY. Chic., 1962. Gift of the College.

NEW AND NONOFFICIAL DRUGS 1962. J. B. Lippincott Co., Phil., 1962. Gift of the American Medical Association, Council on Drugs.

MEDICOLEGAL FORMS WITH LEGAL ANALYSIS, Chic., 1961. Gift of the American Medical Association, Law Department.

A CLINICAL GUIDE TO THE MENOPAUSE. Including a Brief Review of Basic Sex Endocrinology and General Information on Estrogens. N.Y., 1960. Gift of Ayerst Laboratories.

THE BECTON, DICKINSON LECTURES ON STERILIZATION. Presented During the

continued on next page

One Caution When You Buy Mink...



Consult a reliable furrier who is interested in protecting your interests, with honest value and guaranteed quality. Come to Harris, and buy with confidence!

WILLIAM H. Harris

New England's Largest Exclusive Furrier
400 Westminster Street
Our 2nd Half-Century of Fine Fur Tradition



Academic Years 1957-1959 as Part of the Curriculum in Bacteriology at Seton Hall College of Medicine and Dentistry. (N.J., n.d.) Gift of Becton, Dickinson & Company.

MULTIPLE SCLEROSIS: Prognosis and Treatment. A Nosometric Approach by Leo Alexander, Austin W. Berkeley and Alene M. Alexander. Charles C. Thomas, Publisher, Springfield, Ill., 1961. Gift of the Chandler Hovey Fund for Research and Treatment of Multiple Sclerosis.

CIBA COLLECTION OF MEDICAL ILLUSTRATIONS. v. 3. A Compilation of Paintings on the Normal and Pathologic Anatomy of the Digestive System. Part II. Lower Digestive Tract. Prepared by Frank H. Netter, M.D. Edited by Ernst Oppenheimer, M.D., Summit, N.J., 1962. Gift of Ciba Pharmaceutical Products, Inc.

CIBA FOUNDATION SYMPOSIUM ON TUMOUR VIRUSES OF MURINE ORIGIN. Editors for the Ciba Foundation: G. E. W. Wolstenholme and Maeve O'Connor. Little, Brown & Co., Bost., 1962. Gift of Ciba Pharmaceutical Products, Inc.

SHOCK PATHOGENESIS AND THERAPY. An International Symposium. Stockholm, 27th-30th, June, 1961. Sponsored by Ciba. Chairman, U. S. von Euler, Stockholm. Edited by K. D. Bock. Springer-Verlag, Berl., 1962. Gift of Ciba Pharmaceutical Products, Inc.

SHIP FEVER. The Fiske Fund Prize Dissertation for 1849. By Henry Clark, M.D. (Autographed) and CROUP; Its History, Nature and Theatment by Albert Newman, M.D. The Fiske Fund Prize Dissertation No. XVII, June 1855. Gift of the Cincinnati General Hospital Medical Library.

DIRECTORY OF PROFESSIONAL ELECTROLOGISTS, 1961. Gift of *Electrolysis Digest.*

HARVARD MEDICAL ALUMNI ASSOCIATION BULLETIN, Fall, 1961. Gift of the Association.

W. K. KELLOGG FOUNDATION. Report for 1961. Gift of the Foundation.

LIFE INSURANCE ASSOCIATION OF AMERICA, Aims, Services, Committees, Membership. N.Y., 1962. Gift of the Association.

DIRECTORY OF THE OFFICERS AND FELLOWS OF THE MASSACHUSETTS MEDICAL SOCIETY. Alphabetical and Local Lists as of July 1, 1961. Gift of the Society.

APHORISMS OF C. H. MAYO AND WILLIAM J. MAYO. Collected by F. A. Willius, M.D. Whiting Press, Rochester, 1951. Gift of the Mayo Clinic Library.

THE MERCK MANUAL OF DIAGNOSIS AND THERAPY. Charles E. Lyght, M.D. and Others, Editorial Board, 10th ed. Published by Merck, Sharp and Dohme Research Laboratories, Rahway, N.J., 1961. Gift of Merck, Sharp and Dohme.

RECOGNIZING THE DEPRESSED PATIENT by Frank J. Ayd, Jr., M.D. Grune & Stratton, Inc., N.Y., 1961. Gift of Merck, Sharp and Dohme.

PROCEEDINGS OF THE CONFERENCE ON GENETIC POLYMORPHISMS AND GEOGRAPHIC VARIATIONS IN DISEASE. Edited by Baruch S. Blumberg, M.D. Grune & Stratton, Inc., N.Y., 1961. Gift of the National Institute of Arthritis and Metabolic Diseases.

INDEX CATALOGUE OF THE LIBRARY OF THE SURGEON-GENERAL'S OFFICE. 5th ser. v. 2, 3. Subjects. (A-M, N-Z). Wash., 1961. Gift of the National Library of Medicine.

REPORT ON THE SMALL POX, in the City of Providence, from January to June 1859, by Edwin M. Snow, M.D. Prov., 1859. City Document #4. Gift of the Library of the New York Academy of Medicine.

SMALL POX AND THE PROTECTIVE POWER OF VACCINATION . . . by Edwin M. Snow, M.D., Prov., 1869. City Document #44. Gift of the Library of the New York Academy of Medicine.

ANNUAL REPORT, 26th, 1961. Gift of the Rhode Island Dept. of Employment Security.

DIVISION OF VITAL STATISTICS, 1960. (Prov., 1961) Gift of the Rhode Island Department of Health.

THE LIVING BODY by Charles H. Best and Norman B. Taylor. 3rd ed. Henry Holt & Co., N.Y., 1952. Gift of the Rhode Island State Library Extension.

THE PHYSIOLOGY OF MAN by L. L. Langley and Emanuel Cheraskin. McGraw-Hill Book Co., Inc., N.Y., 1954. Gift of the Rhode Island State Library Extension.

ANNUAL REPORT OF SMITH KLINE & FRENCH FOUNDATION, Phil., 1960. Gift of the Foundation.

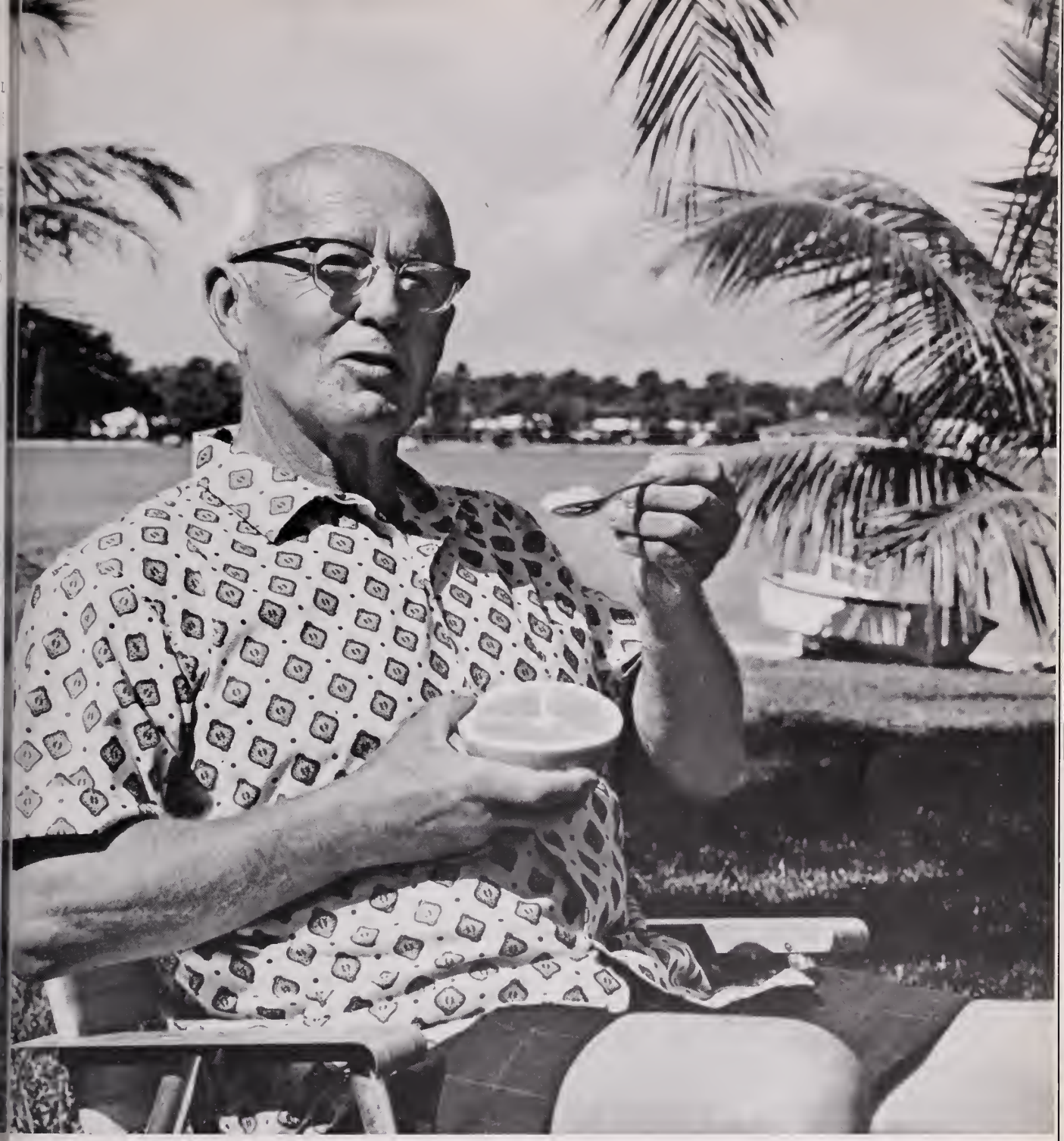
ARS MEDICA. A Collection of Medical Prints Presented to the Philadelphia Museum of Art by Smith Kline & French Laboratories. Catalogue Compiled by Carl Zigrosser and Published by the Philadelphia Museum of Art, Phil., 1959. Gift of Smith Kline & French Laboratories.

HEALTH AT HOME, OR HALL'S FAMILY DOCTOR . . . by W. W. Hall. James Betts & Co., Hartford, 1876. Gift of the State Health Library.

ANNOTATED BIBLIOGRAPHY OF STRONTIUM AND CALCIUM METABOLISM IN MAN AND ANIMALS. Agricultural Research Service, U.S. Department of Agriculture. Miscellaneous publication #821, Wash., v. 1961. Gift of the U.S. Government.

ATLAS OF AVIAN HEMATOLOGY. Re-

continued on page 594



The good life–just what the doctor ordered

Sea and sun are both in his doctor's orders — so is that grapefruit he's eating with such gusto. Citrus fruit is a wonderful way for this patient or any patient to get his daily quota of vitamin C . . . to enjoy something good to eat, tasty and satisfying but not rich.

Not all patients are so lucky as to have retired to Florida, where they can just reach out to pick citrus fruit off their own orange and grapefruit trees. But any patient anywhere can get the same benefits of the natural vitamin C in Florida oranges, grapefruit, and tangerines . . . thanks to modern methods of processing fresh fruit. Whether it is frozen, canned, or in cartons, 98% of the vitamin C content of the fruit is preserved.

Grapefruit and other citrus fruits filled with vitamin C are valuable in the nutrition of every age group. Among the teen-agers, vitamin C is one of the two nutrients most often low in the diet. Infants, too, need generous amounts of vitamin C; and they will take it readily when it comes to them in the form of delicious orange juice.

When your patient chooses *Florida* citrus, he can be sure of getting fruit filled with natural goodness and of just the right sweetness. Florida citrus is unexcelled because a State commission watches over the entire Florida citrus crop to see that it meets the world's highest standards for fresh, frozen, canned, or cartoned citrus fruits or juices.

© Florida Citrus Commission, Lakeland, Florida

ON THE MEDICAL LIBRARY BOOKSHELVES

continued from page 592

gional Poultry Research Laboratory, East Lansing, Mich., Animal Husbandry Research Division, Agricultural Research Service, Monograph #25, Wash., v. 1961. Gift of the U.S. Government.

SYPHILIS. Modern Diagnosis and Management. Public Health Service Publication #743. Wash., 1960. Gift of the U.S. Government.

BOOKS IN PRINT 1960. Edited by Sarah L. Prakken. R. R. Bowker Co., N.Y., 1960. Gift of the Veterans Administration Hospital.

Through our Exchange with Lund University, we acquired:

THE EFFERENT LOOP DUMPING SYNDROME. Its Relation to Intestinal Absorption as Studied by an Intubation Technique by Stig G. Borgström. Translated by Mr. L. James Brown. Acta chir. scandinav., sup. 265. Stockholm, 1960.

ON THE PROGNOSIS AND NATURAL HISTORY OF ACUTE RHEUMATIC FEVER AND RHEUMATIC HEART DISEASE by Paul Hall. Lund, 1961. Acta med. scandinav., sup. 362.

CONTINUOUS RECORDING AND CONTROL OF VENTRICULAR FLUID PRESSURE IN NEUROSURGICAL PRACTICE by Nils Lundberg. Translated by Mr. L. James Brown. Copenhagen, 1960. Acta psych. & neurol. scandinav., sup. 149.

ON THE ANATOMY AND VIBRATORY PATTERN OF THE HUMAN VOCAL FOLDS. With Special Reference to a Photoelectrical Method for Studying the Vibratory Movements by Bertil Sonesson. Translated by Mr. L. James Brown. Lund, 1960. Acta oto-laryngol., sup. 156.

HISTAMINE METABOLISM IN BRAIN by Thomas White. Lund, 1961.

The following titles, from the Russian Scientific Translation Program, were sent to us by the United States Department of Health, Education, and Welfare:

WORKS OF THE INSTITUTE OF HIGHER NERVOUS ACTIVITY. Pathophysiological Series. Academy of Sciences of the USSR. 3 vols. Moscow, 1955-57; Jerusalem, 1960.

WORKS OF THE INSTITUTE OF HIGHER NERVOUS ACTIVITY. Physiological Series. Academy of Sciences of the USSR. 3 vols. Moscow, 1955-59; Jerusalem, 1960-61.

PROBLEMS OF EVOLUTION OF PHYSIOLOGICAL FUNCTIONS. A Collection Dedicated to the 75th Birthday of L. A. Orbeli. Academy of Sciences of the USSR. Moscow, 1958; Jerusalem, 1960.

PROBLEMS OF THE PHYSIOLOGY OF THE PROCESSES OF FATIGUE AND RECOVERY. Academy of Sciences of the Ukrainian SSR. Kiev, 1958; Jerusalem, 1960.

NEW SOVIET SURGICAL APPARATUS AND INSTRUMENTS AND THEIR APPLICATION. Edited by M. G. Anan'yev. Pergamon Press, Lond., N.Y., 1961.

SURGICAL TREATMENT OF MITRAL STENOSIS. A Textbook for Physicians. Edited by Prof. A. N. Bakulev. Moscow, 1958; Jerusalem, 1961.

ENZYMOLOGY IN THE USSR. A Review of the Literature by Chester W. DeLong. Public Health Service Publication #782. Wash., 1960.

CONTROL OF IMMUNOGENESIS BY THE NERVOUS SYSTEM. Edited by Professor A. N. Gordienko, Rostov-On-Don State Medical Institute, Rostov-On-Don, 1958; Jerusalem, 1960.

THE NEOPLASTIC PROCESS AND THE NERVOUS SYSTEM. Edited by R. E. Kavetskii. Kiev, 1958; Jerusalem, 1960.

GLANDS OF INTERNAL SECRETION IN THE EMBRYONIC DEVELOPMENT OF BIRDS AND MAMMALS. Edited by M. S. Mitskevich. Moscow, 1957; Wash., 1959.

THE METABOLISM OF IODINE AND THE THYROID HORMONES by Ya. Kh. Turakulov. Academy of Sciences of the Uzbek SSR. Tashkent, 1959; Jerusalem, 1961.

THEORETICAL AND PRACTICAL PROBLEMS OF MEDICINE AND BIOLOGY IN EXPERIMENTS ON MONKEYS. Edited by I. A. Utkin. Pergamon Press, Lond., N.Y., 1960.

EVOLUTIONARY REGULARITIES AS REFLECTED IN THE EPILEPTIFORM REACTION OF ANIMALS TO HIGH PARTIAL OXYGEN PRESSURE by A. V. Voino-Yasenetskii. Moscow, 1958; Jerusalem, 1960.

THE RICKETTSIAL DISEASES by P. F. Zdrodovskii and H. M. Golinevich. Pergamon Press, Lond., N.Y., 1960.

THE STUDY OF INFLUENZA by V. M. Zhdanov and Others. Public Health Service Publication #792. Wash., 1960.

Review copies received from the RHODE ISLAND MEDICAL JOURNAL are listed separately and are, therefore, not included in *On the Medical Library Bookshelves.*

Several gifts were received:

RESOLUTION of the Board of Officers of the National Medical Association in Honor of Dr. A. H. Hayes of Boston, Mass., Jan. 1, 1876. Gift of Nathan A. Bolotow, M.D.

CIBA CLINICAL RECORDS, v. 1, #1-6—Management of the Insomniac (Max S. Sadove); The Control of Congestive Heart Failure (Arthur C. DeGraff); Progress in the Therapy of Advanced

continued on page 600

your patient becomes



tractable

with

Trancopal®

(brand of chlormezanone)

effective tranquilizer and skeletal muscle relaxant

THE TRUE "TRANQUILAXANT"
FOR A RELAXED MIND IN A RELAXED BODY

- **quiets the anxiety of the tense patient**
- **eases tense muscles, relaxes the patient**
- **reported side effects are rare and usually mild.**

AVAILABLE: 200 mg. Caplets® (green colored, scored), 100 mg. Caplets (peach colored, scored), each in bottles of 100.

DOSAGE: Adults, 1 Caplet (200 mg.) three or four times daily; children (5 to 12 years), from 50 to 100 mg. three or four times daily.

Before prescribing, consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

Winthrop LABORATORIES, New York 18, N. Y.

1728M

BOOK REVIEWS

ATLAS OF CLINICAL ENDOCRINOLOGY
by H. Lisser, M.D. and Roberto F. Escamilla, M.D.
The C. V. Mosby Co., St. Louis, 1962. $23.00

This is a second edition of the book on ENDOCRINOLOGY by Lisser and Escamilla, professors of the great University of California School of Medicine. The authors have emphasized brevity of words and have demonstrated everything by pictures. One may forget the words he reads, but these pictures will remain imprinted in the mind. These professors, I am sure, must have been good teachers because all their facts are tabulated in 1-2-3 order, which is very easy to grasp. Cases are presented with the pictures of each case shown before, during, and after treatment. It is far different from reading the ordinary textbook.

This is the type of book for the clinician to read quickly when confronted with endocrine problems. It is very easy to peruse several diseases in a short time to gain some quick knowledge when trying to study a patient clinically. The authors have emphasized the clinical aspect of present-day knowledge and speak of the positive facts that are known today.

Something new to me was the description of many types of obesity with various fat distribution in patients who did not show any clinical evidence of endocrine disease by any methods of investigation, showing that we do not know all about fat distribution. In some instances, these patients were put on rigorous diet for weeks with no weight loss. I believe this is an important phenomenon for the physician to recognize.

The chapter on hypothyroidism was very fascinating to me. The chapter on primary and secondary aldosteronism was a very good one and presented in a very simplified manner. The chapter on ovarian tumors causing masculinization was also a very interesting one.

I do believe this is a good modern book for quick reference for the present-day clinician.

MARK A. YESSIAN, M.D.

CIBA FOUNDATION SYMPOSIUM ON SOMATIC STABILITY IN THE NEWLY BORN. Editors for the Ciba Foundation: G. E. W. Wolstenholme and Maeve O'Connor. Little, Brown & Co., Boston, 1961. $10.00

Neonatal deaths are due according to statistics chiefly to alterations of the brain and lungs, and to malformations and infections. Why are newborns resistant to anoxia, yet show a twenty fold mortality rate increase in infectious diarrhea when compared with older infants?

Twenty-seven international authorities have analyzed comprehensively these and other questions of the physiological functions of the newborn. Examined, debated, and compared in the human and other animals are kidney function and the excretion of water and solutes, the metabolic effects of fasting and food, the cardiovascular system, endocrine function, the stability of the nervous system, and much more.

We are impressed by the treatment which Doctor Usher is using for the respiratory distress syndrome in the newborn, but as Doctor James points out in the symposium we don't know why it works. Usher provides calories, but doesn't provide many, and he doesn't know how many of these calories come out in the urine. Usher provides alkali, but he doesn't provide much, not enough to correct the acidosis. Usher does provide fluid, and this may prove to be one of the most important aspects of the therapy.

One authority comments that dangerously low figures for glucose are never found in full-term infants or in premature infants older than two days. In the respiratory distress syndrome figures for blood glucose before death show a wide scatter with a few values as low as in fatal hypoglycemia seen in the three-month-old infant. Are the pallor, apneic spells, and limpness which occur in the respiratory distress syndrome the same as those which occur in the hypoglycemic episodes of the intrauterine malnutrition syndrome?

I enjoyed this book; so will any doctor who sees infants regularly. It will take only a few minutes to read the Informal Summary of the Clinical Implications of the Proceedings by C. A. Smith, pp. 346-353, and the General Discussion, pp. 356-365 at the end of the book, and recharge the human battery with thoughts concerning the care of the newborn.

The Ciba Foundation truly continues to promote international co-operation in medical research.

PETER L. MATHIEU, JR., M.D.

continued on page 598

THE AMERICAN ASSOCIATION
OF MEDICAL MILK COMMISSIONS
SUPERVISES THE PRODUCTION OF

Certified MILK



1. CLEANER. Lowest bacteria-count. Milk checked before each milking. All utensils, bottles, and equipment sterilized before use.

2. BETTER-PROTECTED. Strictest medical supervision of herds and employees. Frequent examinations and laboratory-control AT THE FARM are required.

3. AUTOMATIC MILKING. Cows are milked automatically by electric machine. Milk is bottled without exposure to air or human touch.

4. BOTTLE CLOSURES. Must be of the highest quality to provide complete protection for the milk and bear approval of The American Association of Medical Milk Commissions.

5. MORE NUTRITIOUS. Cows scientifically fed balanced ration. Nutrition control from soil to delivery of milk. Same diet all year.

6. LONGER-LASTING, BETTER-TASTING. Diet control, special handling, and shortest time of delivery from cow to consumer assure fine fresh flavor that lasts for weeks.

7. THE DOCTOR'S MILK. Produced, processed, bottled on farms supervised by Medical Milk Commissions. Each bottle bears the seal of the A.A.M.M.C. and names of the supervising Commission and producing farm.

MILK COMMISSION OF PROVIDENCE MEDICAL ASSOCIATION

HILLSIDE FARMS, INC., 1308 Phenix Ave., Cranston, WI 2-3400
Produced at Hillside Farm, Cranston, R. I.

H. P. HOOD & SONS, 135 Harris Ave., Providence, DE 1-3024
Produced at Hood Certified Farm, Beverly, Mass.

WHITING MILK CO., 40 Tockwotton St., Providence, GA 1-5363
Produced at Hampshire Hills Farm, Wilton, N. H.

BOOK REVIEWS

continued from page 596

POSTPARTUM PSYCHIATRIC PROBLEMS by James Alexander Hamilton, M.D. C. V. Mosby Company, St. Louis, 1962. $6.85

Doctor Hamilton's book on psychiatric problems following pregnancy, despite its shortcomings, is recommended to the obstetrician primarily because its perusal may help prevent the more serious emotional disorders occasionally found after delivery. The shortcomings of the book are not so much in what he presents but, rather, in the style of presentation.

The deletion of Chapter III would not only improve the book but would reveal less of the author's anxiety in treating these illnesses.

DAVID J. FISH, M.D.

THE SENESCENT IN INDUSTRY. Medical Evaluation of His Employability and Health Maintenance by George C. Dowd, M.D. Published Under a Grant from the American Geriatrics Society. n.p., 1960

This book is a rather concise but uniquely complete work dealing with the great potential of our senior citizens in industry. It is of great value especially today when there are many forces abroad giving the impression that, when one reaches the age of sixty-five, the individual's productive years are over. This book would indicate otherwise and gives the physician, and all who are interested in furthering the employment of the senescent, an excellent guide to the best methods to use to properly evaluate this country's great potential among the aged.

It shows that the oldster has a good if not a better work record in many cases than the younger individual. This is due to a definitely well-motivated attitude toward work. They have more experience, and a definite desire to prove their worth and to show that there are still many more useful days left in their life span.

It also has an excellent survey report form correlating job demands and physical capacity. I believe it is an excellent work for all who deal with the senescent and especially for the industrial physician as an aid in evaluating pre-employment and retirement physical examination.

FRANK D. FRATANTUONO, M.D.

CIBA FOUNDATION SYMPOSIUM ON RENAL BIOPSY. Clinical and Pathological Significance. Edited for the Ciba Foundation by G.E.W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Margaret P. Cameron, M.A. Little, Brown and Company, Boston, 1962. $10.50

This excellent book is based on a SYMPOSIUM sponsored by the Ciba Foundation. The Symposium brought together a group of distinguished men from Europe and the United States, who discussed different findings in the kidney elicited through the technique of renal biopsy. Quite a bit of this work deals with pure research and was done with the electronic microscope. At the end of each paper there is a general discussion by the different authorities on the subject. Practically all the medical renal diseases are covered in this group of papers, with three papers dealing with the basic structure of the kidney. Renal biopsy itself is a fairly easy procedure for the clinicians to be familiar with. Probably the most important part of this technique is the pathological diagnosis of a minute piece of tissue which has been taken from a diseased kidney. According to the different authors of this book, it is a very valuable procedure.

I found this book to be very well compiled and very useful, although it deals primarily with the research aspect of renal biopsy.

DANIEL S. LIANG, M.D.

CHARLES V. CHAPIN AND THE PUBLIC HEALTH MOVEMENT by James H. Cassedy. Harvard University Press, Cambridge, Mass., 1962. $5.75

Doctor Cassedy was first introduced to the work of Doctor Chapin and the Providence Health Department during the year 1949-50 while a graduate student at Brown University, working for a Master's degree in History. The life of Doctor Chapin made a lasting impression on him and as a result, his thesis for his Ph.D. degree in 1959 was on *Doctor Charles V. Chapin and the Modern Public Health Movement.*

In his research, Doctor Cassedy found no full-length biography or study on Doctor Chapin and has now corrected this omission. Doctor Cassedy has done more than fill this void, he has brought Doctor Chapin and his philosophy to life.

The book is easy to read and its full index and appendix would have brought a pleasant smile to Doctor Chapin's face. Doctor Chapin admired factual documentation, but objected to an author attempting to fit facts to preconceived ideas.

Alexander Dumas in his *Word to the Reader,* prefacing his delightful novel *The Company of Jehu,* stated that the novelist was more accurate in historical facts and background than the historian. The reason advanced by Dumas was that historians were more interested in the dates than in the reasons behind the events. In his treatment of Doctor Chapin's life, Doctor Cassedy has followed Dumas the novelist and yet at the same time has kept to the historical facts. He has done this by organizing the

book in chapters on the various facets of Doctor Chapin, rather than on strictly chronological events.

It is of interest to note that Doctor Chapin always stressed that one should first get the facts and then reason from what is known, rather than trying to fit facts into any preconceived idea. Thus, Doctor Chapin always insisted on the original record, fearing that in copying, one might inadvertently make a biased error. He was proud of the epidemiological forms he developed for the Providence Health Department. If others did not see fit to follow, it was their loss.

Those of us who knew Doctor Chapin will be stimulated by this book to recall many pleasant memories. Those who only knew him by hearsay will gain a rich insight into the character of the man. All of us should be thankful that this man lived as long as he did and was responsible for so much good in the field of public health. It should be remembered that Doctor Chapin not only sounded the death knell for terminal fumigation but that he was also one of the first to show that immunity was relative and there was no such thing as "lasting immunity" in life. In other words, this book will brush away many cobwebs of misconceptions and will stimulate clearer insights into the facts of Public Health and Preventive Medicine.

Doctor Cassedy is to be commended on an excellent factual history of the life of Doctor Charles V. Chapin.

JOSEPH SMITH, M.D.

J. E. BRENNAN & COMPANY
Leo C. Clark, Jr., B.S., Reg. Pharm.
Apothecaries
Two Convenient Locations
5 North Union Street Pawtucket, R. I.
140 Central Avenue Seekonk, Mass.
7 Registered Pharmacists
Pharmacy License #226

Curran & Burton, Inc.
INDUSTRIAL
AND WHOLESALE
COAL **OIL**
17 CUSTOM HOUSE STREET
PROVIDENCE, R. I.
DExter 1-3315



Wherever you go forget your telephone calls. We'll take them for you, day or night.

MEDICAL BUREAU
of the
Providence Medical Association

ON THE MEDICAL BOOKSHELVES

concluded from page 594

Hypertension (H. Mitchell Perry, Jr.); the New Hypertensive Patient (Travis Winsor); New Therapeutic Concepts in Epilepsy (Charles H. Carter) and Eczema: Acute and Chronic (Harry M. Robinson, Jr.). Gift of Mr. Morton W. Saunders.

CERTIFICATE OF MEMBERSHIP in the Rhode Island Medical Society Given to Frank T. Fulton, M.D., Dec. 4, 1902. Gift of Marshall N. Fulton, M.D.

PROGRAM of the One Hundred and Fiftieth Anniversary Dinner, *New England Journal of Medicine*, and Sesquicentennial Number, January 4, 1962. Gift of Seebert J. Goldowsky, M.D.

REPAIRING of the Library copy of *Sailor's Physician* by Usher Parsons (2nd ed.). Gift of Seebert J. Goldowsky, M.D.

MEDICINE CHESTS for the Instrument Collection. Gift of Mrs. Ernest C. Maby of Kittery, Maine.

CIBA CLINICAL RECORDS, v. 2, #1, 2— The Control of Congestive Heart Failure (A. C. DeGraff) and Osteoporosis: The Most Prevalent Bone Disease (W. C. Kuzell). Gift of Daniel D. Young, M.D.

COMMITTEE ON MEDICAL ECONOMICS

concluded from page 588

with the practice of medicine and, as is apparent from the poll of our own membership, weaken and destroy the concept of full service benefits for persons within specified incomes.

Health and Accident Insurance

The committee has recently reviewed in detail the health and accident and disability insurance program of the Providence Medical Association and the Society, and it has made recommendations for improvement of the basic contract. The committee anticipates that some of its suggestions for improvement of the coverage will be effected by the insurance carrier in the immediate future.

The new disability insurance program of the American Medical Association was also reviewed. The Committee is of the opinion that this program does not meet a basic insurance need of physicians.

Respectfully submitted,

STANLEY D. SIMON, M.D., *Chairman*

PATRONIZE JOURNAL ADVERTISERS

INDEX OF ADVERTISERS

	PAGE
Air Ambulance Service	573
Ames Company	587
E. A. Anthony	563
Armour Pharmacy	553
Bene & Co.	583
J. E. Brennan	599
Burroughs Wellcome	551, 554-555
Curran & Burton	599
Derosier Agency	583
Duffy-Mott Company	589
Endo Laboratories	545
Florida Citrus Commission	593
Fuller Memorial Sanitarium	580
General Mills	544
Health Havens	573
Wm. H. Harris	591
Lederle Laboratories	546, 550
Thomas Leeming	547, 577
Eli Lilly & Co.	Front Cover, 3rd Cover
Medical Bureau	599
Medical Milk Commission	597
Munroe Dairy	581
Parke, Davis & Co.	Inside Front Cover and 541
Physicians Service	Back Cover
R.I. Hospital Trust	542
A. H. Robins	Insert between 548-549, 549
G. D. Searle	556
Smith, Kline & French Laboratories	552, 579
Viking Hotel	573
Wallace Laboratories	585
Warwick Club Beverages	591
Winthrop Laboratories	575, 595



the case of the missing ampoule

People aren't perfect—neither are machines. Both can slip up occasionally. Take an ampoule in a paper carton for example. How can we be absolutely sure that the ampoule is really inside? ■ Here's how: A machine folds the carton, inserts the ampoule, seals the carton, and then places it on the finishing line. Further down the line, the detective waits—a jet of air sweeping across the finishing line just strong enough to blow an empty carton off the belt. Properly filled cartons proceed for further inspection and packaging. ■ Perhaps a small point, but it is another in a long series of control measures designed to deliver quality pharmaceuticals every time.

Eli Lilly and Company • Indianapolis 6, Indiana, U.S.A.

Lilly

290326

BRIEFS

FROM THE PHYSICIANS SERVICE PLAN OF
THE RHODE ISLAND MEDICAL SOCIETY

The Heart Of The Matter. . .

"If For One Year Everyone In This Country Used Commercial Health Insurance Instead Of Blue Cross. It Would Cost The Public $1.500.000.000 More."

—Frank Groner. *Past President*
American Hospital Association

Blue Cross and Blue Shield are non-profit plans. Here in Rhode Island this is especially significant. For the local Physicians Service and Blue Cross plans have the lowest administrative costs of any state-wide plan in the nation.

While there may be questions about a particular policy or procedure. there is no question about the fundamental fact that Physicians Service returns more benefits for the patient's dollar.*

*(A national Blue Shield cost analysis study reported recently that Rhode Island Physicians Service had the lowest cost per contract of any of the 51 Blue Shield plans taking part in the study . . . and about half the average cost of the other plans.)

31 CANAL ST.. PROVIDENCE 1, RHODE ISLAND · PHONE: TEMPLE 1-7300

DECEMBER, 1962

RHODE ISLAND

Medical Journal

THE N.Y. ACADEMY OF MEDICINE
JAN -9 19
LIBRARY

Volume XLV, No. 12

Table of Contents, page 603

ASTHMA—
A CLASSIC INDICATION FOR
HALDRONE®
(paramethasone acetate, Lilly)

Haldrone produces rapid remission of the symptoms of asthma and controls the patient over extended periods with relative freedom from side-effects. In recommended dosage, Haldrone is unlikely to cause sodium retention and has little or no effect on potassium excretion.

Suggested daily dosage for asthma:
Initial suppressive dose . . . . . 6-12 mg.
Maintenance dose. . . . . 2-6 mg.
Supplied in bottles of 30, 100, and 500 tablets: 1 mg., Yellow (scored), and 2 mg., Orange (scored).

This is a reminder advertisement. For adequate information for use, please consult manufacturer's literature. Eli Lilly and Company, Indianapolis 6, Indiana. 240120

Lilly

when urinary tract infections present a therapeutic challenge...

CHLOROMYCETIN®

(chloramphenicol, Parke-Davis)

Often recurrent...often resistant to treatment, urinary tract infections are among the most frequent and troublesome types of infections seen in clinical practice.[1,2] In such infections, successful therapy is usually dependent on identification and susceptibility testing of invading organisms, administration of appropriate antibacterial agents, and correction of obstruction or other underlying pathology.

Of these agents, one author reports: "Chloramphenicol still has the widest and most effective activity range against infections of the urinary tract. It is particularly useful against the coliform group, certain Proteus species, the micrococci and the enterococci."[1] CHLOROMYCETIN is of particular value in the management of urinary tract infections caused by *Escherichia coli* and *Aerobacter aerogenes*.[3] In addition to these clinical findings, the wide antibacterial range of CHLOROMYCETIN continues to be confirmed by recent *in vitro* studies.[4-6]

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100. See package insert for details of administration and dosage.

Warning: Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, granulocytopenia) are known to occur after the administration of chloramphenicol. Blood dyscrasias have occurred after both short-term and prolonged therapy with this drug. Bearing in mind the possibility that such reactions may occur, chloramphenicol should be used only for serious infections caused by organisms which are susceptible to its antibacterial effects. Chloramphenicol should not be used when other less potentially dangerous agents will be effective, or in the treatment of trivial infections, such as colds, influenza, or viral infections of the throat, or as a prophylactic agent. *Precautions:* It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

References: (1) Malone, F. J., Jr.: *Mil. Med.* **125**:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* **34**:187, 1959. (3) Ullman, A.: *Delaware M. J.* **32**:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* **108**:48, 1961. (5) Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: *Antibiotics & Chemother.* **10**: 694, 1960. (6) Lind, H. E.: *Am. J. Proctol.* **11**:392, 1960.

68961

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit 32, Michigan



again in 1962, Doctor



more families looked to you, and Physicians Service, than ever before!

During 1962, your Physicians Service Plan helped an unprecedented number of Rhode Island families—your patients— to meet the financial burden of illness.

Tentative 1962 figures show . . .

- More than 308,000 cases paid . . . an increase of 15,000 cases over 1961.
- Almost $8,850,000 paid for the surgical and in-hospital medical care of Rhode Islanders . . . an increase of nearly $400,000 over the previous year.
- Over 23,000 more subscribers added . . . for a total of nearly 609,000 Rhode Islanders enrolled.
- Over 41,000 more persons enrolled under Plan B . . . for a total of 189,000 under Plan B.

In providing benefits totalling almost $8,850,000 for subscribers this year, Physicians Service processed over 300,000 doctors' claims . . . that's 1,300 every working day . . . 2½ claims every minute!

RHODE ISLAND MEDICAL SOCIETY
PHYSICIANS SERVICE

The RHODE ISLAND MEDICAL JOURNAL

Editorial and Business Office: 106 Francis Street, Providence, R. I.

Editor-in-Chief: SEEBERT J. GOLDOWSKY, M.D.

Managing Editor: JOHN E. FARRELL, SC.D.

Senior Editors

ALEX M. BURGESS, SR., M.D. HENRI E. GAUTHIER, M.D.

Advisory Board

(in addition to editors listed above)

JOHN A. DILLON, M.D. JOHN F. W. GILMAN, M.D. ROBERT V. LEWIS, M.D.
PETER L. MATHIEU, M.D. JOSÉ M. RAMOS, M.D. ROBERT W. RIEMER, M.D.
JACK SAVRAN, M.D. LESTER L. VARGAS, M.D.

Owned and Published Monthly by
THE RHODE ISLAND MEDICAL SOCIETY
Second-class postage paid at Providence, Rhode Island
Copyright, 1962, the Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island
Single copies, 25 cents . . . Subscription, $2.00 per year.

Volume XLV, No. 12 December, 1962

TABLE OF CONTENTS

PAGE

BOXING — ITS PROS AND CONS, *A. A. Savastano,* M.D. 617

TREATMENT OF STAPHYLOCOCCUS ENDOCARDITIS IN COMMUNITY HOSPITALS, *José M. Ramos,* M.D., AND *Anthony Caputi,* M.D. 621

MEDICAL LICENSURE IN RHODE ISLAND,
A Review of the History and Current Status of the Regulation By Statute of the Practice of Medicine . . . *Thomas B. Casey; Earl F. Kelly,* M.D.; *Michael DiMaio,* M.D., AND *John C. Myrick,* M.D. 625

VISITING HOSPITALS ON THE DARK CONTINENT,
Laurence A. Senseman, M.D. 630

EDITORIALS

Medical Costs and the Doctor 631

Comparative Medicine 631

Chiropractic Trends 632

Council of the N.E. State Medical Societies 633

DEPARTMENTS

Through the Microscope 608

District Medical Society Meetings 641

Book Reviews 644

Scanning the Medical Literature 649

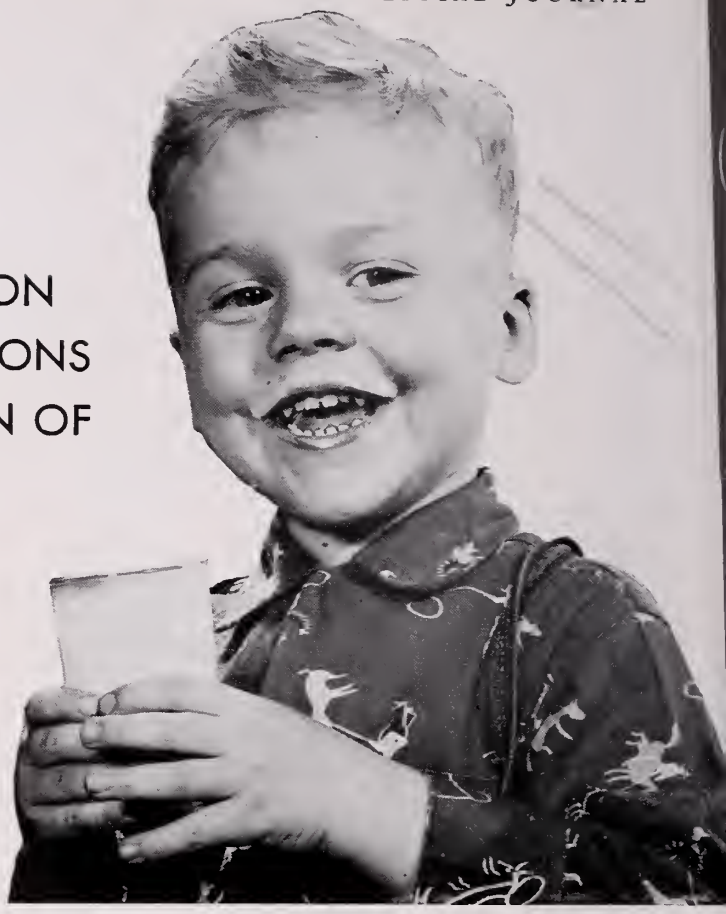
In the Editor's Mailbox 652

Certified MILK

REG. U. S. PAT. OFF.

THE AMERICAN ASSOCIATION OF MEDICAL MILK COMMISSIONS SUPERVISES THE PRODUCTION OF

Certified MILK



1. CLEANER. Lowest bacteria-count. Milk checked before each milking. All utensils, bottles, and equipment sterilized before use.

2. BETTER-PROTECTED. Strictest medical supervision of herds and employees. Frequent examinations and laboratory-control AT THE FARM are required.

3. AUTOMATIC MILKING. Cows are milked automatically by electric machine. Milk is bottled without exposure to air or human touch.

4. BOTTLE CLOSURES. Must be of the highest quality to provide complete protection for the milk and bear approval of The American Association of Medical Milk Commissions.

5. MORE NUTRITIOUS. Cows scientifically fed balanced ration. Nutrition control from soil to delivery of milk. Same diet all year.

6. LONGER-LASTING, BETTER-TASTING. Diet control, special handling, and shortest time of delivery from cow to consumer assure fine fresh flavor that lasts for weeks.

7. THE DOCTOR'S MILK. Produced, processed, bottled on farms supervised by Medical Milk Commissions. Each bottle bears the seal of the A.A.M.M.C. and names of the supervising Commission and producing farm.

MILK COMMISSION OF PROVIDENCE MEDICAL ASSOCIATION

HILLSIDE FARMS, INC., 1308 Phenix Ave., Cranston, WI 2-3400
Produced at Hillside Farm, Cranston, R. I.

H. P. HOOD & SONS, 135 Harris Ave., Providence, DE 1-3024
Produced at Hood Certified Farm, Beverly, Mass.

WHITING MILK CO., 40 Tockwotton St., Providence, GA 1-5363
Produced at Hampshire Hills Farm, Wilton, N. H.



Relieves Anxiety and Anxious Depression

The outstanding effectiveness and record of safety with which Miltown relieves anxiety and anxious depression—the type of depression in which either tension or nervousness or insomnia is a prominent symptom — has been clinically authenticated time and again during the past seven years. This, undoubtedly, is one reason why physicians still prescribe meprobamate more often than any other tranquilizer in the world.

Miltown®

meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50. Also as MEPROTABS® — 400 mg. *unmarked*, coated tablets; and in *sustained-release* capsules as MEPROSPAN®-400 and MEPROSPAN®-200 (containing respectively 400 mg. and 200 mg. meprobamate).

WALLACE LABORATORIES / *Cranbury, N. J.*

Clinically proven in over 750 published studies

1. Acts dependably — without causing ataxia or altering sexual function
2. Does not produce Parkinson-like symptoms or liver damage
3. Does not muddle the mind or impair physical activity

CM-7972

scratching helps...



but Calmitol stops itching fast!

For every kind of pruritus—for adults or children—safe, fast-acting CALMITOL Ointment soothes itching on contact, helps prevent secondary trauma caused by scratching. And low-cost, conservative CALMITOL is non-sensitizing. CALMITOL Ointment is available at all pharmacies in 1½ oz. tubes and 1 lb. jars. For more stubborn pruritus, CALMITOL Liquid in bottles of two fluidounces.
THOS. LEEMING & CO., INC., New York 17

CALMITOL®

for anything that itches

When you choose an anorectic—

"Does it help the patient maintain the proper diet, is it free of dangerous side effects, and does the patient like it?"[1]

Perhaps you'll find, as Stevenson did, "['Eskatrol'] seems to meet these criteria better than most."

1. Stevenson, L.E.: M. Ann. District of Columbia *30*:409 (July) 1961.



ESKATROL®
SPANSULE®
brand of sustained release capsules

PRESCRIBING INFORMATION

Formula: Each 'Eskatrol' *Spansule* sustained release capsule contains Dexedrine® (brand of dextro amphetamine sulfate), 15 mg., and Compazine® (brand of prochlorperazine), 7.5 mg., as the dimaleate.

Recommended Dosage: One 'Eskatrol' *Spansule* capsule daily, taken in the morning.

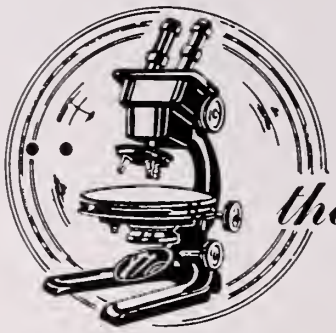
Side Effects: Side effects (chiefly nervousness and insomnia) are infrequent, and usually mild and transitory.

Cautions: Clinical experience has demonstrated that 'Eskatrol' (containing the phenothiazine derivative, prochlorperazine) has a wide margin of safety and that there is little likelihood of blood or liver toxicity or neuromuscular reactions (extrapyramidal symptoms). The physician should be aware, however, of their possible occurrence.

'Eskatrol' *Spansule* capsules should be used with caution in the presence of severe hypertension, advanced cardiovascular disease, or extreme excitability.

Prescribing information adopted Jan. 1961

Smith Kline & French Laboratories SK&F

THROUGH . . .  *the Microscope*

Private Duty Nurses Raise Rates

The members of the Private Duty Nurses' Section of the Rhode Island State Nurses' Association raised their rates from $2.00 to $2.50 per hour, as of October 15, 1962. This is in line with the neighboring states' salaries.

Through this increase, it is hoped that more nurses will be attracted to return to nursing, thereby alleviating the desperate shortage of private duty nurses that now prevails. The Private Duty Nurses' Section of the Rhode Island State Nurses' Association and the Rhode Island Central Directory for Nurses will continue to supply competent private duty nurses suited to the needs of the community.

College of Surgeons Elects Rhode Islanders as Fellows

At the annual five-day Clinical Congress of the American College of Surgeons, held in Atlantic City last month, four Rhode Island physicians were elected Fellows as the result of their fulfilling comprehensive requirements for acceptable medical education and advanced training as specialists in one or another of the branches of surgery.

Those receiving the distinction from Rhode Island were Doctors Carmine J. Capalbo, Henry C. McDuff, Jr., John R. Stuart, and J. John Yashar.

FDA Warns Against Dangerous Drug "Liefcort"

Sufferers of arthritis were warned today by the Food and Drug Administration that the drug Liefcort, which is being obtained from Canada, is imminently dangerous and may not legally be imported into the United States.

FDA Commissioner George P. Larrick said that federal officers are detaining importations by persons who are obtaining the drug in Canada as a result of reading about it in a national magazine article last May. He said that reports of serious reactions to the drug are reaching the Food and Drug Administration. These include severe uterine bleeding.

Liefcort contains potent hormones including estradiol, prednisone and testosterone. FDA analysis showed the product contains 10 times the therapeutic dose of estradiol, Commissioner Larrick said.

According to the FDA Bureau of Medicine the hormones are capable of causing severe toxic effects. Prednisone has and is being used in the treatment of arthritis but there are hazards in its use and the dosage must be carefully regulated. In some patients, the drug causes severe symptoms of toxicity. Testosterone and estradiol have never been observed to exert any beneficial effect in arthritis and may also produce serious side effects.

Liefcort was developed by and is being promoted by Robert Liefman, M.D., who is wanted by U.S. Marshals for selling a baldness "cure." Liefman fled to Canada before he could be apprehended and is not licensed to practice medicine there. The drug is labeled as being distributed by Endocrine Research Laboratories, Beaurepare, Que., Canada. It is compounded in Liefman's home, FDA said.

Joint Blood Council Dissolves

Having successfully achieved its major goal of co-ordination the Joint Blood Council, Inc., is being dissolved.

Within the past seven years a national peacetime blood program of major significance has been worked out under the leadership of the Council. The impetus created by the Joint Blood Council's Member Institutions in this venture assures that blood and its derivatives will be readily available in the future for all who need them.

In fact, the work of the Council has been carried out so well that co-ordination of the existing blood programs can now be realized without the existence of a separate corporation. Reports and policies distributed by the organization have been widely accepted. Plans are under way for each of the five component institutions to continue liaison of blood interests through advisory representatives who will meet occasionally.

Early in 1955 the American Medical Association joined with the American National Red Cross, the

continued on page 610



the case of the missing ampoule

People aren't perfect—neither are machines. Both can slip up occasionally. Take an ampoule in a paper carton for example. How can we be absolutely sure that the ampoule is really inside? ■ Here's how: A machine folds the carton, inserts the ampoule, seals the carton, and then places it on the finishing line. Further down the line, the detective waits—a jet of air sweeping across the finishing line just strong enough to blow an empty carton off the belt. Properly filled cartons proceed for further inspection and packaging. ■ Perhaps a small point, but it is another in a long series of control measures designed to deliver quality pharmaceuticals every time.

Eli Lilly and Company • Indianapolis 6, Indiana, U.S.A.

Lilly

290326

THROUGH THE MICROSCOPE

continued from page 608

American Hospital Association, the American Association of Blood Banks, and the American Society of Clinical Pathologists in forming the Joint Blood Council, a nonprofit professional service organization which was urgently needed to co-ordinate the existing national interests in blood.

Nine Million Elder Citizens Protected by Health Insurance

Insuring organizations all across the nation are now making new efforts to extend health insurance coverage to those persons 65 years of age and older who are not yet protected, according to the Health Insurance Institute.

Past efforts have proven quite successful, said the Institute. In 1952, an estimated 26 per cent of the aged had some form of private health insurance coverage through insurance companies, Blue Cross-Blue Shield, and other health care plans.

Now it is estimated that 55 per cent of the total non-institutionalized aged population are protected, the Institute declared. This adds up to more than nine million persons 65 and over who have health insurance, including some 4.75 million elderly covered by insurance companies.

Health insurance protection for the aged is being provided in many ways. Some of the methods are through the sale of individual policies, the use of mass enrollment techniques, continuing group coverage on a worker when he retires, and through coverages for younger persons which become paid-up-for-life at age 65.

More than 200 insurance companies are actively issuing health insurance policies to the aged, and several of these companies also offer paid-up-at-65 policies. The Institute said a study it made showed that seven out of every ten workers covered under group health insurance policies issued by insurance companies during 1961 have the right to retain their coverage when they retire.

The mass enrollment programs are open to all applicants irrespective of past medical histories, and without medical examination. The Institute said these programs fall into two main types — those offered in a particular region or even nationally by one company, and those offered in a single state by a pool of companies.

Most active in the former area have been the Continental Casualty Company, Chicago; Mutual of Omaha; and Fireman's Fund Insurance Group, San Francisco. In the latter area the active plans are Connecticut 65, Massachusetts 65, and New York 65.

Air Pollution Afflicts 212 Met Areas

Approximately 90 per cent of the U.S. urban population lives in localities which have air pollution problems. Large city or small, industrialized or not, few cities are immune, says the U.S. Department of Health, Education and Welfare.

Fifteen years ago the air pollution problem was virtually unknown. Los Angeles did not institute its first anti-smog measure until 1947. Ten years ago, it was estimated that total losses due to pollution in the whole nation amounted to $10 per person per year. Now it is estimated to be $65 in economic costs alone.

The World Health Organization says the automobile is a major contributor to smog. If so, smog may begin to appear less frequently since, starting with 1963 models, the automotive industry is planing to install blowby devices on all new cars.

Poisons also are rejected into the air from the chimneys of homes and commercial enterprises, from refineries and storage tanks. These pollutants are in the form of smoke, fumes and liquid droplets from lead, sulfur, arsenic, hydrogen sulfide, hydrogen fluoride, nitrogen dioxide and other waste.

The U.S. Public Health Service lists 212 metropolitan areas as having air pollution "problems." Approximately 90 per cent of the urban population lives in these localities.

It appears that the larger the community, the dirtier the air. One study found air over the dirtiest nonurban area was far cleaner than that over urban areas.

U.S. industry is reported by the PHS to be spending as much as $300 million annually for air pollution control measures. Current efforts to deal with the problem involve the research activities of the PHS, its technical assistance to states and communities, and state and local control programs, which vary widely in scope and effectiveness.

continued on page 612

FOR RENT

DOCTOR' OFFICE SUITE

at

322 Broadway Providence, R. I.

Call: WI 2-3122 or ST 1-1140

PATRONIZE JOURNAL ADVERTISERS

RELIEVE THE COLD SUPPRESS THE COUGH WITH NEW

'EMPRAZIL-C'

TABLETS

ANTITUSSIVE ▪ DECONGESTANT ▪ ANALGESIC

Each tablet contains:

Codeine Phosphate*	15 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Acetophenetidin	150 mg.
Aspirin (Acetylsalicylic Acid)	200 mg.
Caffeine	30 mg.

*Warning—may be habit forming.

Complete literature available on request.

Also available without codeine as

'EMPRAZIL'®

TABLETS



BURROUGHS WELLCOME & CO. (U.S.A.) INC., TUCKAHOE, N.Y.

THROUGH THE MICROSCOPE

continued from page 610

Michigan Economic Survey of Aged Refutes Federal Planners

A new survey of the economic condition of American families, made by the University of Michigan Survey Research Center, proves again the injustice of forcing higher payroll taxes on the nation's workers to buy health care for the aged.

The statement was made by George M. Fister, M.D., president of the American Medical Association, in a news release accompanying an evaluation of the Michigan survey.

"Analysis of the survey findings once again demonstrates, as other studies have, that the aged as a group are substantially better off on the average than younger Americans," Doctor Fister said.

"It proves that the proposed program of nationalized health care for the elderly would be an intolerably unfair burden on wage earners by forcing them to pay health-care bills for the aged, the vast majority of whom are well able to take care of themselves."

Doctor Fister said: "The people who are advocating this program — and they include administration officials, labor leaders and certain political candidates — have painted a dismal picture of the aged as a group living in virtual poverty and needing taxpayers' help in paying their medical bills.

"The truth is a great deal different. As shown by the findings of the University of Michigan survey, aged families, far from destitute and impoverished, actually own considerably more assets and owe fewer debts than younger families. Corresponding evaluation of cash incomes reveals that because of tax exemptions and credits, size of families, and other advantages enjoyed by persons over 65, the gap in income per family member between aged and younger families is relatively small."

Doctor Fister said the survey shows:

1. The median value of total assets owned by families with the head of the family over age 65 was $8,349 in 1960, almost twice as much as the $4,839 which was the median value of total assets of all other age groups as determined by the study. (The term family is substituted for "spending unit," the basis of the study, for greater clarity.)

2. The median value of equity in a home for the over-65 families was $4,559, almost 4½ times as much as the $1,028 reported for younger families.

3. The median value of liquid assets was almost 2½ times as great for the over-65 families — $1,012 compared with $460.

4. Sixty-four per cent of the aged families are homeowners, and 53 per cent of these own their homes free of mortgage. In contrast, 53 per cent of younger families are homeowners and only 18 per cent have no mortgage indebtedness.

5. Sixty-three per cent of over-65 families own assets valued at $5,000 or more compared with 47 per cent of younger families. And 41 per cent of the aged hold assets valued at $10,000 or more, compared with 27 per cent of younger groups, while 18 per cent have assets of $25,000 or more, contrasted with only 9 per cent of younger families.

6. Among aged families, 74 per cent had no personal debt, compared with 34 per cent of younger families, and 86 per cent reported no installment debt, compared with 48 per cent of all other age groups.

Rhode Island Blue Plans Offer Major Medical Coverages

The Walco Electric Company, Providence, is the first company to enroll under the new Blue Cross and Physicians Service Major Medical program, Arthur F. Hanley, executive director of the health plans, announced recently.

The new plan, made available several weeks ago, provides a wide range of health services not now covered by Blue Cross and Physicians Service, and is aimed at helping subscribers with long-term and catastrophic illnesses.

Albert E. Becker, office manager of Walco Electric, said that the new program will be effective December 1 for their 85 employees. The plan for Walco employees has a $100 deductible, and then pays 80 per cent of their covered health care expenses up to a maximum of $20,000.

The Major Medical plan is presently being offered only to groups of 50 or more, which includes 700 companies and 370,000 potential subscribers now enrolled in such groups under the Blue Cross and Physicians Service plans. Groups with under 50 employees and individual subscribers are not yet eligible, but may be in the future, Mr. Hanley reported.

The Major Medical program covers such services as prescription drugs and medicines outside the hospital, health supplies such as wheelchair rental and orthopedic braces, ambulance service, special nurses, doctor's home and office visits, and diagnostic examinations.

Mental disorders are covered in the hospital the same as any other illness. But for mental care provided in the hospital out-patient department or outside the hospital, the major medical pays 50 per cent of the costs instead of the usual 75 or 80 per cent.

It is not necessary for a subscriber to be hospitalized to receive major medical benefits, since a large number of the services are covered outside the hospital, the plans said.

When a subscriber requires hospital or surgical care, he will first use his present Blue Cross and Physicians Service benefits. He will then pay a deductible amount, such as $100, out of his own pocket.

continued on page 614

INDICATION: *Accidental trauma*



INDICATED:
Chymoral®

cuts healing time in accidental trauma

Whether the patient presents the simple edema and inflammation of a sprained ankle or the severe lacerations and bruising from a violent accident, immediate adjunctive use of Chymoral speeds resolution of traumatic manifestations. Chymoral modifies the inflammatory reaction to trauma, dissipates edema and blood extravasates, improves regional circulation, and thus aids the body's natural reparative activities. In other general practice areas, too, Chymoral cuts healing time. Excellent results have been achieved in acute sinusitis, bronchitis, bronchial asthma, emphysema, chronic pelvic inflammatory disease, and acute thrombophlebitis.[1-5]

Controls inflammation, curtails swelling, curbs pain

1. Beck, C., *et al.*: Clin. Med. 7:519, 1960. 2. Teitel, L. H., *et al.*: Indust. Med. *29*:150, 1960. 3. Billow, B. W., *et al.*: Southwestern Med. *41*:286, 1960. 4. Clinical Reports to the Medical Department, Armour Pharmaceutical Company, 1960. 5. Taub, S. J.: Clin. Med. 7: 2575, 1960.

ARMOUR PHARMACEUTICAL COMPANY
KANKAKEE, ILLINOIS
Originators of Listica®

CHYMORAL

Chymoral is an ORAL anti-inflammatory enzyme tablet specifically formulated for intestinal absorption. Each tablet provides enzymatic activity, equivalent to 50,000 Armour Units, supplied by a purified concentrate which has specific trypsin and chymotrypsin activity in a ratio of approximately six to one. ACTION: Reduces inflammation of all types; reduces and prevents edema except that of cardiac or renal origin; hastens absorption of blood and lymph extravasates; helps to liquefy thick tenacious mucous secretions; improves regional circulation; promotes healing; reduces pain. INDICATIONS: Chymoral is indicated in respiratory conditions such as asthma, bronchitis, rhinitis, sinusitis; in accidental trauma to speed absorption of hematoma, bruises, and contusions; in inflammatory dermatoses to ameliorate acute inflammation in conjunction with standard therapies; in gynecologic conditions such as pelvic inflammatory disease and mastitis; in obstetrics as episiotomies and breast engorgement; in surgical procedures as biopsies, hernia repairs, hemorrhoidectomies, mammectomies, phlebitis and thrombophlebitis; in genitourinary disorders as epididymitis, orchitis and prostatitis; in dental and oral surgery as fractures of the mandible or maxilla, difficult or multiple extractions, and alveolectomies. CONTRAINDICATIONS: None known. INCOMPATIBILITIES: None known. Antibiotics as well as generally accepted measures may be coadministered. SIDE EFFECTS: Mild gastric upsets, rarely encountered. DOSAGE: Recommended initial dose is two tablets q.i.d.; one tablet q.i.d. for maintenance. SUPPLIED: Bottles of 48 and 250 tablets.

CHYMORAL *ORAL systemic anti-inflammatory enzyme tablet*

THROUGH THE MICROSCOPE

continued from page 612

Then the Major Medical plan pays 80 per cent of the covered expenses, up to $20,000 under the most common program. Variations of the deductible, the maximum amounts, and other factors are offered to groups.

The maximum benefits, such as $20,000, are in addition to the subscriber's present protection and apply separately to each enrolled family member, the plans explained. However, only half the total maximum is available within one year.

The maximum amounts are for the entire time a subscriber is covered under the major medical plan. But once a subscriber has used up $2,000 or more of his benefits, he can be restored to the full coverage again through a physical examination or by returning to work for at least thirteen weeks.

Some exceptions to the services covered are rest cures, job-connected injuries, services and supplies for personal convenience, routine physical examinations, and routine maternity cases.

Approved Medical Schools Now Number 87

Two medical schools were added to the list of accredited institutions during the past year, bringing the total to 87, the annual report on medical education of the American Medical Association showed today.

The new additions are the University of Kentucky College of Medicine, Lexington, and the California College of Medicine, Los Angeles, formerly the College of Osteopathic Physicians and Surgeons.

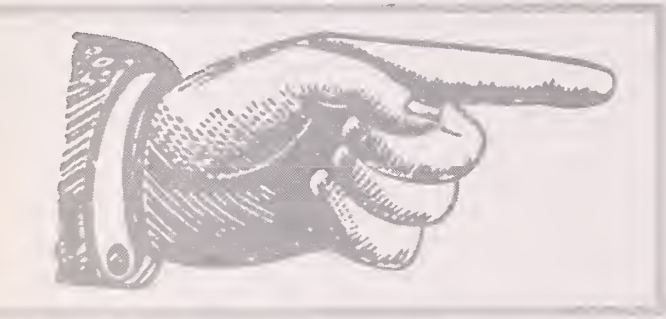
Approval is granted by the A.M.A. and the Association of American Medical Colleges. There are now no unapproved medical schools in the nation.

The 1961-62 report, prepared by the A.M.A. Council on Medical Education and Hospitals, said "10 or 12" new medical schools are currently being planned.

Five universities — Brown, Rutgers, Connecticut, New Mexico and Texas — are proceeding with plans announced last year to establish two- or four-year medical schools, the report said, adding:



more physicians specify







hotos posed by professional models

aquasol A®
capsules

than any other vitamin A product when indicated in

ACNE
dry skin
keratosis follicularis
ichthyosis
pityriasis rubra pilaris
night blindness
metaplasia of mucous membranes

"In almost every state there is some consideration for the possibility of developing new schools within the next decade. Of the many states that have initiated formal or informal considerations of the feasibility of establishing a new school, Arizona, California, Maryland, Massachusetts, Michigan, New York, and Ohio seem most likely to be the sites of new schools in the foreseeable future."

Sixty-seven medical schools completed or began construction of additional facilities in the 1961-62 school year, the council reported.

Reporting on the number of applicants to medical schools, the council said a decline was recorded for the fifth straight year.

"The decrease amounted, however, to only 16 students, hardly a significant number, and it now seems probable that the formerly progressive decline has been checked," it said. "Based upon estimates of applications for the 1962-63 class and increased enrollments in undergraduate colleges, the expectation is that the number of applicants will be shown to have increased for 1962-63 and will continue to increase for several years."

Although various explanations have been offered for the decline in medical school applicants, the council said "the problem seems to be largely the fact that many new and important careers have opened up for the college graduate, during a period of years in which a relatively small group of men and women reached college age. In retrospect it would appear that this heavy competition for the depression crop of babies should have been anticipated by the profession . . . and accepted with greater equanimity. In spite of the many cries of alarm, there is little evidence that the profession has suffered any real harm through lack of applicants to date."

The total number of students enrolled in medical schools for 1961-62 was 31,078, which represents an increase of 790 students over the previous year, largest increase for any one year since 1951, the report showed. Approval of the California College of Medicine accounted for 355 of the 790 additional students.

continued on page 650

physically — its microscopically fine **aqueous** vitamin A particles pass through the intestinal barrier more easily and may reach affected local area more readily through . . .
faster, more complete absorption

physiologically — provides all the known physiologically active isomers of the natural vitamin A complex which are believed to be directly utilizable in certain enzyme processes (in contrast to certain forms of synthetic vitamin A which require conversion in the body) for . . .
fully comprehensive results

gastronomically — with allergenic factors removed and free from "fishy" taste, Aquasol A is . . .
well tolerated and burpless

the original aqueous, natural vitamin A capsules

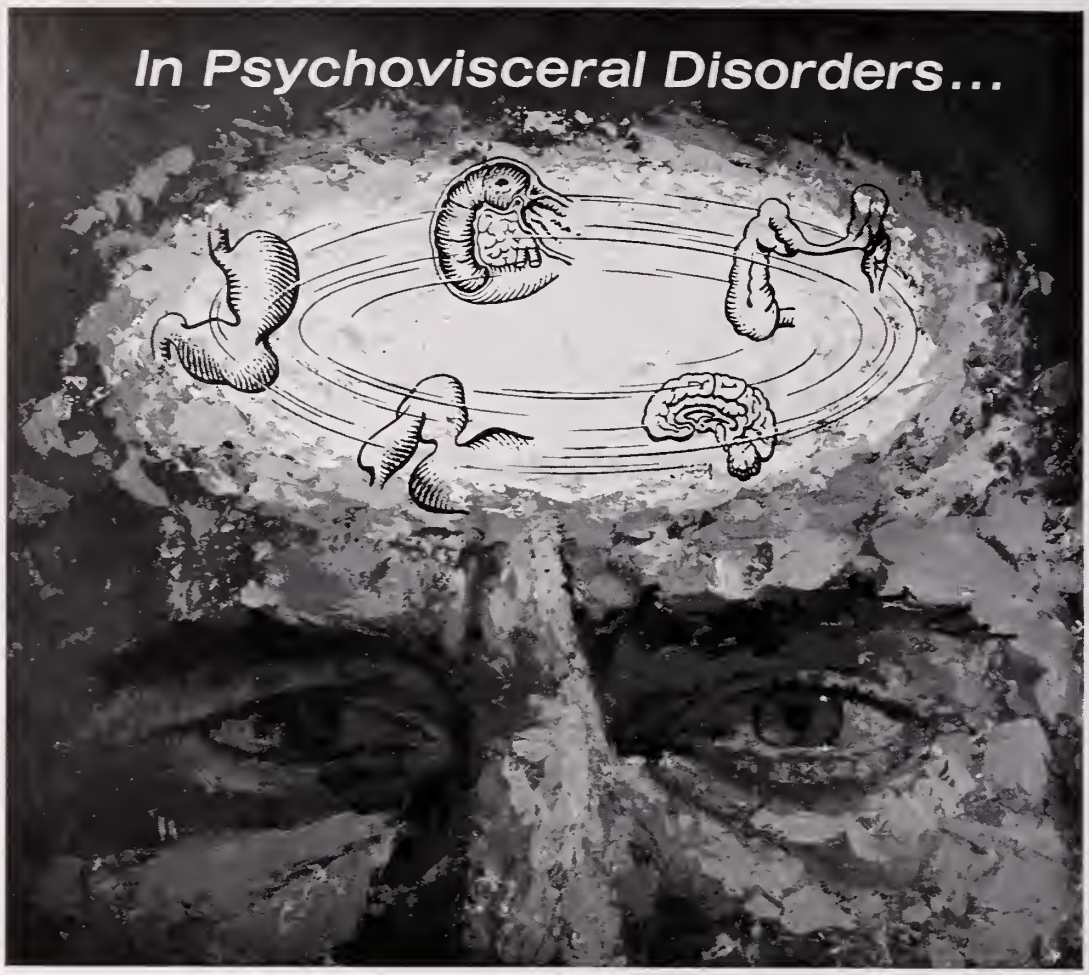
aquasol® A
capsules

two potencies:
25,000 U.S.P. Units
50,000 U.S.P. Units
water-solubilized natural vitamin A per capsule

Bottles of 100, 500 and 1000 capsules.

Samples and literature upon request.

u. s. vitamin & pharmaceutical corp.
Arlington-Funk Laboratories, division
800 Second Avenue, New York 17, N. Y.



...Autonomic Stability

PRO-BANTHĪNE® with DARTAL®

brand of propantheline bromide with thiopropazate dihydrochloride

The combination of PRO-BANTHĪNE with DARTAL provides an autonomic stabilizer of notable efficacy in common psychovisceral disorders.

DARTAL, a particularly well tolerated tranquilizer, allays the central nervous influence in such conditions as peptic ulcer, gastritis, pylorospasm, spastic constipation and mucous or ulcerative colitis. PRO-BANTHĪNE suppresses the emergence of hypersecretion and hypermotility in the stomach and intestines.

By alleviating excessive activity at both ends of the vagus, PRO-BANTHĪNE with DARTAL assures prompt, definite, sustained control not only of severe and persistent gastrointestinal dysfunctions but also of stress-aggravated episodes of more moderate conditions.

USUAL ADULT DOSAGE: One tablet three times a day.

SUPPLIED: Aqua-colored, compression-coated tablets containing 15 mg. of PRO-BANTHĪNE and 5 mg. of DARTAL.

G. D. SEARLE & CO.

CHICAGO 80, ILLINOIS

Research in the Service of Medicine

The RHODE ISLAND MEDICAL JOURNAL

VOL. XLV DECEMBER, 1962 NO. 12

BOXING — ITS PROS AND CONS

A. A. SAVASTANO, M.D.

The Author. *A. A. Savastano, M.D., of Providence, Rhode Island. Chairman, Committee on Medical Aspects of Sports, Rhode Island Medical Society; Orthopedic Surgeon, Department of Athletics and Student Health, University of Rhode Island.*

THE DEATH of Benny "Kid" Paret from head injuries received in a championship prize fight on March 24, 1962, at Madison Square Garden, New York City has already triggered a storm of criticism of boxing as it is conducted in this day and age. Many articles have appeared in the newspapers, magazines, and professional journals condemning and defending the sport. The purpose of this communication is to analyze some of the thoughts which have been expressed on the subject and to set forth some recommendations which I hope will be considered by those who may make changes in the rules and regulations governing boxing.

My interest in the prevention and treatment of all athletic injuries is of long standing. In particular, my interest in boxing has been such that I witnessed practically every boxing card staged at the Madison Square Garden from 1935 to 1945. I have had the personal privilege of treating many boxers, particularly during the time that I was a staff surgeon at the Polyclinic Hospital and Medical School in New York City.

By way of an historical note, boxing had its beginning with the Egyptians about the year 4000 B.C. It was later developed practically to the form as it exists today by the Greeks at the time of their Olympic periods. Offensive and defensive styles, boxing gloves, and mouthpieces were developed during that time. Rules concerning the preparation of the hand and forearm prior to the application of a glove, foul-line rules, and the use of protective head gear were introduced by the Cretans. Even in its early stages, boxing very often came under intense criticism. Emperor Theodosius canceled an ancient series of Olympic games because of the numerous brawls which took place, involving chiefly boxing. Those who come to the defense of boxing as a sport will point out that an honest attempt has been made from time to time to reduce the number of injuries which occur in this sport. As early as 1866, the rules of the Marquess of Queensberry were adopted.

Since boxing is practiced practically worldwide if any rule changes are to be made, every single country which allows the sport should solemnly agree to enforce all adopted rules, regulations and legislation in the strictest sense of the word.

Those who oppose boxing maintain that it is the only sport in which the primary objective of the contestants is to inflict bodily injury on each other.

They further argue that it is the only sport in which a man is declared a winner simply because he has dealt more punishment to his opponent than he himself has received; and that in many cases this punishment consists of rendering one of the contestants unconscious, or even causing his death. Those who oppose boxing emphasize that it is the only sport in which both contestants and spectators may at times forget, or lack, that wonderful quality known as "sportsmanship." In every sport except boxing, the spectators feel sorry when a player is injured, and even applaud him when he is carried off the field. In every other sport there is a provision for "time out" when a player is injured. However, in boxing the injured contestant is put at a disadvantage when injured because his opponent will concentrate then on landing heavier blows with greater rapidity. In every sport except boxing a player who is unable to continue because of injuries leaves the contest with dignity and self-respect. The boxer who is being beaten and cannot fight back effectively is on occasions booed by the spectators. One writer reports that boxing is 83 times more deadly than high school football, 50 times more deadly than college football, and many, many times more deadly than professional football.

There is a group of objectors to boxing who ask why, if bullfighting and cock fighting is banned in most countries, should not prize fighting also be banned? The reply to this question is that animals

continued on next page

are not able to think for themselves, while human beings should be allowed to take a calculated risk if they so desire.

Chief Argument

The chief argument against boxing is that the contents of the skull (chiefly the brain and its appendages) are the chief target. In other words, the objective of most boxers is to inflict trauma and put out of action the brain which is the most important and one of the most vulnerable organs in the human body. It is pointed out further that repeated blows to the brain have led and can lead to blindness, imbecility, paralysis, psychotic disorders, and even death. In the United States alone, approximately ten fighters lose their lives yearly as a result of brain injuries sustained in boxing bouts. Those who escape severe brain damage may carry with them for the remainder of their lives such earmarks of a boxer as keloid scarred cheeks and eyebrows, flat saddle noses, and so-called cauliflower ears.

Anatomically speaking, the brain of an average individual weighs approximately three pounds. It is bathed by circulating cerebrospinal fluid as it lies in its normal position within the skull. A blow to one side of the head causes the brain to strike the skull on the opposite point from which the blow was received. In addition, the brain will slide and wobble within the skull when struck by a blow. When the brain receives a blow, its movements within the skull are not unlike the movements of a piece of jelly when it is pushed to and fro. It has been reported by some neurosurgeons that when the skull is hit and the brain is made to move about within the skull, the sharp edge of the sphenoidal ridge may contuse or even lacerate the brain with resulting hemorrhage, swelling, or both. Neurosurgeons are agreed that brain trauma may be cumulative. Repeated trauma to the brain can result in punch drunkenness, blindness, or even death. Since the essential difference between human beings and animals lies in the frontal lobes of their brains and since it is the frontal lobes which are most often injured in boxing, one can readily understand why punch drunkenness is so prevalent in fighters who remain in the profession for lengthy periods of time. In round figures, it has been reported that approximately 65 per cent of all boxers receive enough brain damage to be reflected in their behavior. The larger number slow up mentally to a significant degree, while the remainder become unmistakably punch drunk.

The objectors to boxing maintain that, if a person becomes even momentarily unconscious as a result of an automobile accident, an industrial accident, or as a result of engaging in any sport other than boxing, he is invariably admitted to a hospital, where he remains under observation and treatment for lengthy periods of time. In addition to the detailed clinical examination which is conducted by competent neurosurgeons and neurologists, such laboratory tests as X-ray films of the skull, encephalograms, and spinal fluid examinations are also done. These patients are seldom if ever allowed to leave the hospital until the chemistry of the spinal fluid has returned practically to normal. The average boxer who has been knocked out is not afforded this type of treatment. In many cases, after he regains consciousness, he receives a short, quick, inadequate examination while still in the ring, and is then allowed to go home on his own. Only those who fail to regain consciousness in the ring are hospitalized. This practice is defended by some physicians on the basis that observations at the ringside and more detailed examinations in the dressing room after the fight fail to reveal any abnormal neurological findings even in those participants who have lost their bouts by a knockout. It is further reported that an encephalogram will not show abnormal tracings even one month after a knockout in most cases. On the other hand, other neurosurgeons state that electroencephalographic studies do demonstrate a rather high percentage of abnormal tracings in boxers who sustain repeated brain trauma, particularly at short intervals. Neurosurgeons explain negative electroencephalograms in the presence of a history of brain injury on the basis that the human brain possesses a generous reserve of highly specialized nerve cells which take up the work of those that are injured and thus produce the numerous temporary false negative electroencephalographic tracings. This phenomenon is compared to one of the kidneys taking up the work of the other when one is lost because of disease or trauma.

It should be emphasized that for every boxer who becomes definitely punch drunk or who dies, many others become forgetful, irresponsible, moody, irritable, thick in speech, and subject to chronic headaches or dizziness.

It has been positively established that the head is the primary target in practically every boxing match. However, secondary targets such as the back of the neck, the heart, the loins, and the solar plexus are not overlooked. If an abrasion or laceration is noticed, an effort will immediately be made to make it larger. If a swelling is noted over the eye or cheek, this then becomes the immediate primary target. In other words, any visible contusion, abrasion, or laceration on a boxer's face during a bout immediately becomes the pinpoint target.

While there are many clergymen, trainers, physicians, and boxers who are in favor of abolishing boxing, there are many others who feel that boxing should be continued under a different set of rules. Doctor Alexeus Rachun, team physician at Cornell

University, Ithaca, New York, states that, "Actually, instead of abolishing boxing, it would be better to see a rebirth of the sport." He further states, "On an amateur level, the emphasis could be shifted to the scientific niceties with a premium on skill and dexterity rather than the knock-out punch." Doctor Rachun is in favor of hard, clean contact games. He feels that, "Stamina and courage of our young athletes should not be discouraged in any way. Boxing fits into the general category. Boxing is a good sport evoking the need for such fine qualities as diligence, application, speed, good reflexes, courage and in the advanced ranks, the ability to take a punch."

Rates 11th in All-Round Development

The Research Study Curriculum Committee of the College Physical Education Association in 1940 conducted a study of 30 different activities and came up with the conclusion that boxing rates eleventh in the list which is considered to be most contributory to the all-around development of boys. The study was repeated in 1951 with the same conclusion, that boxing rates eleventh in the all-around development of boys. If the head injury problem could be eliminated from boxing, I personally feel that the rating would be even higher. It cannot be denied that the conscientious boys who train diligently certainly develop such worthwhile attributes as timing, agility, nimbleness, muscular development, stamina, and confidence.

Those who favor the continuance of boxing with some modifications feel that boxing is as much a business as any other type of commercial enterprise. They speak of the size of the gate receipts in the Tunney-Dempsey, Louis-Schmeling, Louis-Conn, and the Graziano-Robinson fights. Boxing is not only a business for its promoters but it is also a business and a source of livelihood for those who actually engage in it. Many boys with lower than average intelligence quotients but with good physical body build have been given opportunities to earn substantial sums. Doctor Harry A. Kaplan, clinical associate professor of neurosurgery, New York State Univerity, has stated that, "Many speak glibly of the punch-drunk fighter, but how many know of the state of the boxer prior to his entering this sport? While many boys are highly intelligent and have had college training, there are a large number who have an extremely low I.Q., even to the point of being unable to read or write." Doctor Kaplan is of the opinion that many of these boys are often referred to as being punch-drunk. He further states that there are many persons in state hospitals who have never been in a boxing arena who have just about the same makeup, delivery of speech, and as low an I.Q. as many of the boxers who are labeled punch drunk.

Those in favor of not barring boxing make certain recommendations which they feel will serve to continue the sport and reduce the number of injuries. Among the most common recommendations are the following:

1. *More qualified boxing instructors and trainers.* It is an established fact that even in the largest cities only a small number of men are properly qualified or trained to teach boxing. If the sport is to survive, steps should be taken to train more boxing coaches. The training of a fighter means more than teaching him to use his left hand for a jab or his right hand for a solid blow. It means more than teaching him bolo punches or the use of upper cuts. It also means teaching him how to defend himself, and how to develop agility, nimbleness, and stamina. The importance of clean living, keeping good hours, and sportsmanship should be impressed upon him.
2. *Strict licensing boards.* Among the requisites for a boxing license for a fighter should be an excellent and thorough medical examination. A separate thorough examination should be required prior to each fight. No license should be granted to any fighter who has even a minor abnormality in his encephalogram. No fighter should be granted a license until several months after a knockout in which he has become even momentarily unconscious.
3. *Shortening of bouts to 3-6 rounds.* The proponents of this recommendation feel that the shortening of bouts reduces the likelihood of the contestants becoming fatigued. This does not seem to be a reasonable recommendation to me because of the fact that there are many cases on record where a knockout was scored in the first round. Thus the contestants could not possibly have been fatigued. If the boxers train diligently they should show an equal degree of stamina or fatigue regardless of whether it is the eighth, tenth, twelfth, or fifteenth round. It is the one who has not trained well who in most cases becomes fatigued. Of course, the well-conditioned fighter may be struck by a so-called lucky blow and thus be put out of action early in the fight. Also he may be put out of action early because of being over-matched.
4. *The use of heavy gloves.* Some suggest that 14-ounce gloves be adopted, as they would produce the same effect as being struck by a pillow. However, there is a case on record in which a death occurred in a bout at the University of Arizona in 1941 in which 14-ounce gloves were used by both contestants. Pneumatic gloves have been suggested; however,

continued on next page

this could not be expected to be of any value, as the strength of the blow would still come from the other person's strong arm and body.

5. *Head protective gear.* The use of helmets and other types of head gear have been suggested to reduce the number of head injuries. I do not see how a helmet of any size or shape could protect the brain. When a punch is struck on the head, it is not the brain itself which is struck. The force of the blow which hits the head even through a helmet is transmitted to the brain, so that the brain may then hit the opposite side of the skull, or be lacerated or contused by the sphenoidal ridge. Professor Harvey L. Miller of the University of Maryland states that the strongest argument in favor of the helmet is that it prevents the cheap technical knockout such as takes place when lacerations of the scalp or forehead occur. It is reported that in the Sonny Boy West Memorial boxing event three of four bouts in which both contestants were fully helmeted ended in knockouts.
6. *Physician at ringside.* No bout should be conducted without a physician being present at the ringside. A physician should be absolutely and fully empowered to stop a fight whenever he sees fit.
7. *Properly padded corner posts and ring floor.* It has been stated that numerous head injuries take place as a result of the head striking improperly padded corner posts, ring mats, or floors. How to reduce this source of injury is obvious.

The elimination of boxing gloves and the establishment of an "upper foul line" should appease those who propose the banning of boxing. Perhaps some of the promoters will say that if the following rules were adopted, boxing would die a slow natural death in spite of the fact that the number of injuries would undoubtedly diminish.

1. *The elimination of boxing gloves.* I believe that this suggestion was originally made by Doctor La Cava of Rome, Italy. It is unreasonable to expect the unprotected hand repeatedly to strike the head of an opponent without its becoming injured and painful. The more the striking hand is injured, the less the force of each succeeding blow. I would anticipate that more contusions, lacerations, sprains, dislocations, and fractures of the hand would result; however, it is better to have an injury to the hand than an injury to the brain. It is therefore suggested that boxing gloves and bandaging of the hands be eliminated. It is recommended that the boxer be allowed to wear only an ordinary leather glove (not a boxing glove) without any padding whatever under the glove.
2. *Establishment of a second foul line.* As boxing rules now stand a boxer commits a foul when he strikes his opponent below the beltline. It is obvious that, while being struck below the beltline may be painful, there are no recorded deaths from being struck below the beltline. It is also to be noted that when a boxer strikes his opponent below the designated beltline, officials warn the offender not to do it again, and the boxing fans become incensed against him. Objections are raised to the so-called "low blow," even though the receiver of the low blow has well-developed lower abdominal muscles and is probably wearing an adequate genital protective device. On the other hand, when a boxer scores with a heavy solid blow to his opponent's head, he is cheered even though this blow may have caused a permanent injury to its recipient. Since a low foul line is respected by contestants and enforced by referees, why cannot a *high foul line* also be established? It is recommended that the line be placed at the junction of the neck and the chest in front, and encircle the entire neck at this level. Purposely striking an opponent above the upper line or below the lower line should carry an automatic disqualification of the offender. Warnings should not be allowed.

SUMMARY

The future of boxing as it is now practiced seems to be somewhat uncertain. Although ten or more

concluded on page 624

SUGGESTED FOUL LINES



1. High Foul Line
2. Low Foul Line

TREATMENT OF STAPHYLOCOCCUS ENDOCARDITIS IN COMMUNITY HOSPITALS

José M. Ramos, M.D., and Anthony Caputi, M.D.

The Authors. *José M. Ramos, M.D., Senior Physician, Department of Medicine, Newport Hospital, and Anthony Caputi, M.D., Senior Cardiologist, Department of Medicine, Newport Hospital, Newport, Rhode Island.*

In contrast to the subacute form of endocarditis due to streptococcus viridans, staphylococcus endocarditis usually runs a hyperacute and fulminating course and is characterized by being rapidly destructive.

Most cases that have recovered, as was shown by Dowling and his associates, have been those infected with penicillin-sensitive staphylococci. The advent of penicillinase-producing staphylococci in the last few years has made anti-staphylococcal treatment very hazardous, and reports of 50 to 75 per cent mortality have been reported by various hospitals.

Due to the fulminating and rapidly destructive nature of the disease, in the form of extensive destruction of the valves and pronounced, severe myocarditis, it seems that to attack the disease effectively, early diagnosis is of prime importance. Subsequently, the immediate administration of large amounts of antibiotics, selected on the basis of reason and in combinations, until such time as the results of the laboratory tests become available and allow a planned approach, is also a factor of great importance.

Procrastination in using what one might consider to be the appropriate antimicrobial may result in death in a few days, before effective therapy can be administered. Many have died in congestive heart failure, in spite of the fact that appropriate chemotherapy was used, because of the extensive valvular destruction.

Random administration of drugs that have been found inhibitory in disc-tests appears to be a poor approach according to some authors, and frequently gives poor results.

Statistics have also shown that poor prognosis in these cases was usually associated with advanced age, aortic valve involvement, congestive heart failure, and severe alcoholism.

The combination of drugs that has been specifically tailored for staphylococcus appears to be a more rational and effective approach in producing cures in these cases. This paper has been prepared to emphasize this same point.

Case Reports

Case 1. G.E., a forty-five-year-old white male truck driver, was admitted to the general wards of Newport Hospital on March 26, 1962 at 5:30 P.M. with an elevated temperature of 105.4° F. and in delirium tremens with severe tremors of the hands and face. He admitted that he had been drinking rather heavily for the past few days with the intake of a large quantity of brandy during the day. He also admitted that for the last twenty years he was in the habit of drinking large quantities of beer and did not eat very regularly. He avowed, upon questioning, that he had had rheumatic fever at the age of three, and that he had been rejected from military service because of a heart murmur. He stated, however, that he had never had any shortness of breath upon exertion at any time. Upon examination he appeared acutely ill, perspiring profusely, extremely restless with marked tremors of the hands and face. He stated that he had had diarrhea and vomiting for the last day or so and that he felt very sick. His pulse on admission was 120, temperature 105.4° F., respirations 28. His blood pressure was 140/78 mg. Hg. His lungs were clear on auscultation with good thoracic excursions. The heart sounds were of good quality, rhythm was regular, and there was a Grade 2 apical systolic murmur and a rasping, Grade 2, basal systolic murmur with radiation to the neck. There were no splinter hemorrhages noted. The abdomen was soft, and the liver and spleen were not palpable. There was no peripheral oedema. His tendon reflexes were hyperactive, otherwise the neurological examination was noncontributory. The initial laboratory data obtained the following morning showed a hemoglobin of 12.6 grams; red blood cell count 4.6 million; white blood cell count 6.400 with 93 per cent neutrophils; lymphocytes 7 per cent.; monocytes, eosinophils and basophils 0. His hematocrit was 38 per cent and his E.S.R. 53. His urine showed a specific gravity of 1.018 and a pH of 6.0, albumin 2 plus, and 2 plus sugar with no acetone. The venereal disease research laboratories test was non-reactive; urea

continued on next page

nitrogen was 9.5 mg. per cent; fasting blood sugar was 143 per cent. The serum transaminase "P" was 16 units. Streptolysin titer 50 Todd units; C-Reactive Protein positive 1:2; Gamma Globulin more than 3 gm. per cent. The total serum sodium was 149 milli equivalents; potassium 4.6 milli equivalents; chlorides 94 milli equivalents, and a CO_2 content of 19.2 milli equivalents. A chest film done at this time revealed no gross abnormality of the heart or lungs except for some left ventricular prominence. The heart did not seem to appear actually enlarged. There was no pleural involvement. The electrocardiogram revealed an abnormal tracing showing left atrial and left ventricular hypertrophy, with inversion of the T-wave in precordial leads consistent with anteroseptal ischemia or early cor pulmonale.

A blood culture was ordered and while waiting for the laboratory report 5,000,000 units of penicillin were given intramuscularly every 24 hours for possible streptococcus viridans infection along with 200 mgm. of thiamin chloride and vitamin B complex intramuscularly daily because of the probability of a beri-beri heart in this patient who was a known chronic alcoholic.

On the following day, the blood culture was noted to be filled with staphylococcus aureus, sensitive to all antibiotics checked, viz., penicillin, tetracycline, erythromycin, chloramphenicol, streptomycin, oxytetracycline, Furadantin,® kanamycin, and novobiocin. The patient was then given vancomycin, 2 gm. every 24 hours, by intravenous drip in 1000 ml. 5 per cent glucose solution, and this was continued until a total dose of 10 gms. had been given. At this point, vancomycin was discontinued and methicillin was started at the dose of 1 gm. every 4 hours intramuscularly for a period of 15 days. During this entire period penicillin was given concomitantly in the dose of 5,000,000 units over each 24 hour period. At the end of the fifteenth day therapy on Staphcillin,® this drug was discontinued and the patient was then given erythromycin 250 mgm., 4 times daily by mouth, and remained on this medication until his discharge. This was done mainly because of the intense physical discomfort undergone during the past intramuscular therapy.

The patient's blood cultures, taken every 3 days, remained negative from the fourth day following the beginning of therapy and the patient remained afebrile from the twenty-sixth hospital day until discharged. At this time the electrocardiogram revealed an absence of left atrial hypertrophy, lesser evidence of the early cor pulmonale, and a persistence of the left ventricular hypertrophy. On auscultation the predominant lesion appeared to be a mitral valvulitis. At no time did the patient show evidence of failure even after ambulation on his thirty-first day. He was discharged on his forty-second hospital day feeling well and tolerating moderate activity with no ill effects. When seen recently on the usual routine follow-up examination he was doing well and pursuing a gainful occupation with no physical repercussions.

Case 2. M. D., a forty-three-year-old housewife, was seen in consultation in the Newport Hospital with a history of having had dental work performed four weeks earlier. One week following the dental extractions she developed chilly sensations, malaise, and weakness. On admission several days prior to the consultation date, she became pyrexic, weak, and noticed palpitations.

She recalled having had repeated episodes of tonsillitis and colds as a child. There was no history of rheumatic fever. The previous hospital experience consisted of a delivery at eight months gestation of a stillborn infant in 1949. Following this, the patient had had surgical removal of a large cystadenoma of the ovary, which was reported as being benign. She delivered a normal full-term infant in 1952. At that time, it was first noted that she had a persistently rapid pulse. Review of the previous hospitalizations during 1947, 1948, and 1951 failed to reveal any physical findings of cardiac murmur or enlargement.

This acutely ill white female appeared somewhat pale. The blood pressure was 120/72; cardiac rate was 120; respiratory rate was 22. Examination of the optic fundi was negative. There was no evidence of splinter or pinpoint petechiae in the conjunctivae. Hearing was normal and the drums and canals were negative. The nasal passages and oropharynx were negative in appearance except for pale mucous membranes. There were small petechiae in the tips of some of the fingers and toes with considerable tenderness (Osler's nodes). The skin was generally pallid and moist. The heart was moderately enlarged measuring two centimeters beyond the midclavicular line, with dullness in the third left interspace parasternally. There was a Grade IV harsh systolic murmur auscultated in the mitral area and involving the first mitral sound. This was transmitted in diminuendo into the axilla and up into the other valve areas toward the neck, but without transmission into the neck. The rhythm was sinus tachycardia. A-2 equaled P-2; peripheral pulsations were normal; the chest was symmetrical. The lungs were clear to auscultation and percussion. The abdomen was soft and the liver was not palpated. The hepatojugular reflux was negative. The area of splenic dullness appeared to be normal and the tip of the spleen was not palpated. Costovertebral angles were not tender.

Complete blood count revealed a normochromic, normocytic anemia with a hemoglobin of 10 G/100 ml. The hematocrit was 32 per cent. The white

blood count and differential were normal. Urinalysis was unremarkable. The febrile agglutinin tests were negative. The antistreptolysin titre was recorded at 500 Todd units. Throat culture was negative for pathogens. The C-reactive protein was positive in a dilution of 1:2. Blood cultures on three occasions revealed coagulase positive micrococcus pyogenes. Sensitivity studies revealed universal sensitivity to penicillin, tetracycline, erythromycin, chloramphenicol, streptomycin, kanamycin, and novobiocin. The blood-urea nitrogen was 8.9 mg. per cent, the bilirubin total measured 0.7 mg. per cent with 0.5 mg. per cent in the direct phase. Roentgenologic findings of the chest revealed bilateral seventh cerbical ribs and mild cardiac enlargement, left ventricular type. The initial electrocardiogram was within the normal range. The subsequent electrocardiogram recorded one month later revealed minimal ST-T wave changes consistent with digitalis effect.

It was concluded that this patient had rheumatic heart disease with mitral valvulitis and predominant mitral insufficiency complicated by bacterial endocarditis due to micrococcus pyogenes. During the thirty-nine hospital days, the patient was initially pyrexic to 103° F. rectally, gradually decreasing to a normal level on the twenty-fourth hospital day with a spike in temperature to 104° F. on the twenty-sixth day and subsequently a totally normal temperature course. The initial averaging tachycardia of 120 persisted to the thirtieth day of hospitalization when gradual digitalization brought it into the eighty to ninety range. Initial therapy consisted in the use of aqueous penicillin, 1,000,000 units intramuscularly every three hours with streptomycin 0.5 grams intramuscularly twice daily. This was altered within five days because of continuing toxemia and febrile state. The penicillin was increased to 10,000,000 units intramuscularly every three hours in conjunction with intravenous vancomycin 500 milligrams every six hours. The vancomycin was subsequently, within twenty-four hours, altered to one gram intravenously every twelve hours with the subsequent use of sixty to eighty million units of penicillin intravenously which replaced the intramuscular route. The vancomycin therapy was continued for ten days. At the end of two weeks of intravenous penicillin therapy, the intramuscular route was used with aqueous penicillin ten million units intramuscularly every three hours. This was gradually reduced and within two weeks of discharge, oral penicillin was continued with prophylactic penicillin used upon discharge. Three weeks after hospital admission the patient evidenced mild congestive heart failure with the development of venous distention in the neck, the presence of a few basal rales and slight increase in liver size. Digitoxin (1.2 mg.) was given in one dose with a subsequent maintenance dose of 0.1 mg. daily. Within several days, all signs of congestive failure were corrected and this drug was continued upon discharge.

Discussion

Two cases have been presented with recovery from documented staphylococcal endocarditis superimposed upon damaged valves associated with rheumatic heart disease. In both cases penicillin G was used to initiate therapy and continued because of the higher statistical incidence of streptococcus viridans in bacterial endocarditis, and the delay prior to the return of blood culture reports. In Case One, vancomycin and methicillin were added to the treatment as soon as a positive blood culture for staphylococcus aureus was recorded. In Case Two, management involved the use of streptomycin and vancomycin. In both cases the organism was sensitive in a universal fashion to all bacteriostatic and bactericidal agents by the disc method.

In many small community hospitals serum bactericidal tests and tube dilution sensitivity tests are not available. Further, disc sensitivity tests are generally considered unreliable. These factors pose a serious problem to the clinician.

Prior to the availability of vancomycin, methicillin, and oxacillin, combined therapy was necessary because of the development of penicillin-resistant penicillinase producing staphylococci. Combination therapy, according to Jawetz et al.,[1] was necessary using combinations of penicillin G, probenecid, tetracycline, erythromycin, and bacitracin with perhaps 25-50 per cent salvage. The use of the newer drugs should improve the salvage rate to 75 per cent recovery.

On the basis of the limitation of testing techniques in many smaller hospitals; the experience in our cases; and a survey of the literature,[2,3,4] it is recommended that combined therapy with vancomycin and methicillin be used in the management of staphylococcal endocarditis. Duration of therapy should be for three to five weeks with clinical and bacteriologic criteria as guides. While individual drug usage may be feasible, we feel that because of the dangerous and destructive nature of the disease, combined therapy is indicated.

Oxacillin[5] is a newcomer to the therapeutic armamentarium since the writing of this paper and is reputed to have the advantage of adequate gastrointestinal absorption when compared to methicillin. Since oral absorption is relatively variable, methicillin therapy is more logical at this time.

Geraci[2] suggests that vancomycin be prepared by dissolving 1 gm. of the drug in 20 ml. of water and giving each dose intravenously over four minutes. One gram is given every six hours for two days, and 1 gm. intravenously every 12 hours for three to five weeks. This simple method is a considerable

continued on next page

improvement over the more cumbersome and uncomfortable continuous intravenous technique. Azotemia is the only relative contraindication to its use because of the possibility of eighth nerve damage.

Methicillin is generally administered 1 gm. intramuscularly every six hours for three to five weeks.

SUMMARY

1. Two cases of recovered bacterial endocarditis due to staphylococcus aureus superimposed on inactive rheumatic valvulitis are presented.

2. The unavailability of serum bactericidal and tube dilution sensitivity tests in small community hospitals poses a serious problem to the clinician.

3. Therefore, combined vancomycin and methicillin (Staphcillin®) therapy is suggested as the treatment of choice under these conditions because of the destructive characteristics of this disease.

4. Although oxacillin is considered to be an excellent drug, fully absorbed by the oral route, its use in place of methicillin should be considered only after reading the more current literature.

References

[1]Jawetz, E., and Brainerd, M.D.: Staphylococcal Endocarditis: Results of Combined Antibiotic Therapy in Fourteen Consecutive Cases. Am. J. Med. 32:17, 1962

[2]Geraci, J. E.; Nichols, D. R., and Wellman, W. E.: Vancomycin in Serious Staphylococcal Infections. Arch. Int. Med. 109:507, 1962

[3]White, A., and Varga, D. T.: Antistaphylococcal Activity of Sodium Methicillin. Arch. Int. Med. 108:671, 1961

[4]Geraci, J. E., and Heilman, L. R.: Vancomycin in the Treatment of Staphylococcal Endocarditis. Proc. Staff Meet. Mayo Clinic 35:316, 1960

[5]Kirby, W. M. M.; Rosenfeld, L. L., and Brodie, J.: Oxacillin — Laboratory and Clinical Evalution. J.A.M.A. 181:739, 1962

We Offer the Finest Facilities for

CONVENTIONS, SEMINARS, CONFERENCE MEETINGS

1 to 400 persons

NEW MOTOR INN and ALL FUNCTION ROOMS
FULLY AIR-CONDITIONED

Outdoor Swimming Pool, Boating, Fishing, Golfing,
Historic Mansions, World Famous Ocean Drive

Viking Hotel and Motor Inn

"in the center of everything"

NEWPORT, RHODE ISLAND

Telephone 847-3300

BOXING — ITS PROS AND CONS

concluded from page 620

deaths result from boxing yearly, no major changes have been made for many years in the rules and legislation pertaining to boxing. The recent death of Benny "Kid" Paret from injuries received in a championship fight has triggered a storm of worldwide criticism against boxing. The situation as it now stands is that public opinion is in a large sense opposed to the continuation of boxing particularly because of the types of personalities and motives now in control of the major portions of the sport. One of the major objections to boxing is that it is the only existing sport in which the object of the opponents is to hurt each other. Another principal objection to boxing is that the most important organ of the human body — the brain — is the chief target of the opposing contestants, and that not only numerous deaths result from boxing but irreversible head injuries take place, which leave the boxer in a state of punch drunkenness. Many suggestions are made to improve and control the sport and to reduce the number of injuries.

It is hoped that the Boxing Education and Research Foundation will develop some sound ideas regarding safety. It is also hoped that an insurance, welfare, and pension plan can be established, such as exists in some other sports.

References

[1]Steinhaus, A. H.: Boxing — Legalized Murder? Look, v. 14, Jan. 3, 1950

[2]Steinhaus, A. H.: Statement on Boxing in High Schools, J. Health & Phys. Educ. 15:384, 1944

[3]Committee on Medical Aspects of Sports: Statement on Boxing, J.A.M.A. 181:242, July 21, 1962

[4]Novich, M. M.: Reducing Boxers' Injuries Through the Art of Self-Defense, Second National Conference on Medical Aspect of Sports, Nov. 27, 1960. Reprint, American Medical Association, Chic., 1961

[5]Steinhaus, A. H.: Boxer's Brains Swapped for Medals, J. Am. Assoc. Health, Phys. Educ. & Recr. 22:12, Oct. 1951

[6]Steinhaus, A. H.: Should the Sport of Boxing be Discontinued? Yes! Phys. Educator Phi Epsilon Kappa, v. 14, #4, Dec. 1957

[7]Boxing (Editorial), Lancet 1:1185, June 6, 1959

[8]Ressler, T.: Sport or Mayhem, The Lutheran, June 3, 1959

[9]Sports and Medicine, Scope Weekly, Jan. 28, 1959

[10]Sports and Medicine, Scope Weekly, Feb. 25, 1959

[11]Sports and Medicine, Scope Weekly, July 15, 1959

[12]Sports and Medicine, Scope Weekly, July 8, 1959

[13]Sports and Medicine, Scope Weekly, Aug. 10, 1960

[14]Boxing's Future Up to Teachers, AMA News, Dec. 12, 1960

[15]Medicine in Sports, Newsletter Rystan, Mt. Vernon, N.Y., v. 2, #3, April 1962

ORAL POLIO SUNDAY . . . MARCH 1, 1963

MEDICAL LICENSURE IN RHODE ISLAND

A Review of the History and Current Status of the Regulation by Statute of the Practice of Medicine

THOMAS B. CASEY; EARL F. KELLY, M.D.; MICHAEL DIMAIO, M.D., AND JOHN C. MYRICK, M.D.

The Authors. *Thomas B. Casey, Administrator, Division of Professional Regulation, Rhode Island Department of Health.*

Earl F. Kelly, M.D., Chairman, Board of Examiners in Medicine; Past President, Rhode Island Medical Society; Pediatric Chief, Pawtucket Memorial Hospital (32 years); Consultant in Pediatrics, Memorial, Providence Lying-In, and St. Joseph's hospitals.

Michael DiMaio, M.D., Member of Board of Examiners in Medicine; Secretary, Rhode Island Medical Society; Physician, Rhode Island Hospital.

John C. Myrick, M.D., Member of Board of Examiners in Medicine; Chief of Surgery, St. Joseph's and Our Lady of Fatima hospitals.

THE SUBJECT of medical licensure and the standards for certification are a vital concern to all members of the medical profession practicing within our state. This article has been prepared by the official licensing agency to acquaint our physicians with the history of the regulation of medical practice here and the requirements for certification together with the concomitant problems and responsibilities of the licensing officials. It might be noted here that from the time of the adoption of Rhode Island's medical practice law in 1895 to the close of 1961, a total of 3,531 licenses were issued to physicians. In 1961, 1196 of these applied for and were granted annual registration of their license; 107 of these were located outside of this state sufficiently distant from our borders to be excluded from consideration for availability for providing medical care to our residents. This indicates that in 1961 Rhode Island had one currently licensed physician for approximately every 790 residents.

A knowledge of the historical background of the social, economic, and political aspects is helpful in establishing a valid perspective of current accomplishments, needs, and objectives for medical licensure. Governmental regulation of any profession to some degree creates the paradox of promoting public health, welfare, and safety while at the same time laying the foundation for the potential creation of monopolistic conditions restricting free competition. This is an inevitable sequence. Thus the licensing agency must be ever conscious of its obligation in a democratic society to strike a fair balance between freedom and order.

In Europe, as a protective measure for both the community and the practitioner, the professional segments of medieval society organized into guilds or associations. In the early middle ages these were dominated by ecclesiastical influence. In colonial America the true guild idea never did take hold.

> To a large degree, state-wide regulation of the medical profession covering license and competence to practice was delayed until the second half of the eighteenth century, when the earliest American medical societies were established. Unlike the lawyers, doctors were not necessarily considered public servants and did not practice before a body empowered to license. Thus it was not until local and state medical societies existed that rules governing the training and conduct of practitioners were held in common by an organized group. Once established, these societies had no system of legal control over the training and experience of practitioners. By the end of the century, with the rapidly increasing number of practitioners, these societies began to fear for the purity of the profession and the welfare of a society at the mercy of the unqualified. They appealed to the state for recognition.[1]

Early Legislative Efforts

In Rhode Island the first profession to be regulated by statute was pharmacy in the year 1871. The legislature made provision for the licensing and control of persons practicing dentistry in 1881. It was not until 1895 that the General Assembly passed a law regulating the practice of medicine. About eleven years prior to that time, plans and discussions were held by committees from the state medical society and various other medical associations throughout the state regarding the problem "How might the state be rid of the itinerant quack?" In 1885 a committee presented a bill to the

[1]Occupational Licensing Legislation In The States, p. 15. (Chicago: Council of State Governments, 1952)

continued on next page

legislature that would control the practice of medicine but it was defeated in the Senate. The following year another bill was again defeated primarily because of objections from certain elements from the southern part of the state. It is reported by the Rhode Island State Board of Health that beginning in 1888 the Rhode Island Medical Society proposed legislation for the same purpose, and each year a bill was presented in the legislature but failed of enactment. Some of these bills provided for the strictest requirements while others proposed merely a simple registration law, but the legislature was persistent in its refusal to enact a bill that would control medical practice until 1895. The following excerpt from the Annual Report of the State Board of Health for that year is quoted because of its colorful portrayal of conditions prevailing at that time.

> The reason for the failure to pass a medical control act is readily explained when it is considered that the largest representation in this State comes from the rural portion of the State, where the population could not be expected to be familiar with the impositions and chicanery which was practiced in the larger cities. The main desire of the medical profession was to obtain a means of preventing the practice of medicine and surgery by persons who had not the slightest, or only a rudimentary, knowledge of the human system and the conditions going on within the body, and no knowledge of the structure of the same. Any one who saw fit and had sufficient boldness of address could establish himself in business, and placing a placard before the public eye, was privileged to juggle with the feelings, the health and the pocket book of anyone who was sufficiently gullible to employ him. And the laity, especially the poorer class of the public who do not have a family physician at their command and in whom they have confidence, are liable to call upon the first physician whose name is seen upon the side of a house. The case is usually an emergent one, and they have no means of making a distinction, for the signs all read alike. The physician is called, and by some action or advice it is seen by the patient that the person employed to assist him in his need is not what he represented himself to be. He can discharge him, to be sure, but it is too late, the mischief has been done, valuable time has been lost, and his money has been wasted. That the uninformed public might feel a safety in employing a reliable physician or surgeon to care for their welfare, and when called that the employed would at least have intelligence enough to refuse the case if his knowledge was not sufficient to cover the conditions found, it seemed desirable to have a law which should admit to practice only those whose education had been sufficiently complete, either by study or experience, and no others.
>
> The itinerant doctor has been the bane of this State for years, and with the restrictions placed upon them in every State but three, we have had our share and more. Our population is a largely operative one, and one which is easily led to believe statements because they are placed in print. Every physician can testify to the harmfulness of this line of practice as a cause of the increase of his own practice. The wholesale advertiser induces those who have slight ailments to consider that there is little hope for them. They treat them for awhile for some imaginary ailment, and the patient having been thoroughly frightened or led to a state of despondency, and finding no relief, seeks another physician and who may be a physician having some knowledge of the practice of medicine and surgery, and who has cause to thank the liberal advertiser. The saddest form of this imposition is seen in the innumerable cases of consumption and other chronic or incurable disease which the charlatan positively guarantees (the guarantee being his own statement) that he will cure these patients for a given lump sum, if paid down at once. The treatment will be continued until the patient becomes discouraged or dies. The itinerant does not remain long enough to ascertain how much good he had done to the regular profession nor injury to the patient; nor does he care. He remains as long as he can stand the importunities of his patients, and then goes to reap another harvest in some state which opens its arms to him as this one has done for years past. To the regular physician who remains this is the oft repeated story. The patient comes with hopes and money gone, and the state is often asked to pay for the last expenses of the patient, who has often saved the little sum given to the charlatan, for the purpose of a decent burial.
>
> From these statements it will be readily seen why the medical practitioner has no especial interest in the passage of such a law, except the loss of dignity which is involved by permitting an imposition and criminal procedure to continue under the guise of a profession which he had adopted. At the January session of the Legislature of this year a bill was presented which, with little or no opposition, passed and became a law on May 16 and took effect on July 16.

Initial State Control

Thus on July 16, 1895, we have the first governmental control of the practice of medicine in Rhode Island. At that time a person could become licensed as a physician by any of three methods; (1) the possession of a diploma from a reputable medical college endorsed by the State Board of Health and requiring a three year course, (2) by presenting to the Board satisfactory evidence that the applicant

was reputably engaged in the practice of medicine or surgery in this state prior to January 1, 1892, (3) the submission of the applicant to an examination by the Board to determine if the applicant possessed sufficient knowledge of medicine and surgery to qualify for licensure. The report calls attention to a sudden influx of "foreign and irresponsible" persons who suddenly appeared or professed to have arrived in this state a few months before the ascribed limit of time for the obtaining of a medical license by exemption from examination. These irresponsible persons, it is reported, used every manner of illegal procedure and misrepresentation to gain their ends and a livelihood. The report states, "It is astonishing to see the names of reputable physicians placed against the statement that they know these persons and state that they were reputably engaged in the practice of medicine before January 1, 1892. The names are obtained with the ease of a signature to a petition for a fourth of July celebration and are respected by the Board with this value." During the first year of operation of the Medical Practice Act the Board considered over four-hundred and fifty applications and conducted several examinations. Seventeen meetings were held for that express purpose.

In 1914 the Medical Practice Act was amended by the General Assembly to provide for the licensing of osteopaths. The licenses were issued by the State Board of Health upon recommendation of a Board of Examiners in Osteopathy that was appointed by the State Board of Health. Again in 1927 the so-called Medical Practice Act was further amended by the Legislature to provide for the licensing of chiropractors. That type of license was also issued by the State Board of Health on recommendation of a State Board of Chiropractic Examiners, the members of which were appointed by the governor with the advice and consent of the Senate.

The State Board of Health was replaced by the Public Health Commission in 1929 by a reorganization act passed by the Legislature. The functions of the new commission included the licensing and regulation of medical practitioners and the supervision of the examining boards for the other disciplines of the healing art. In 1935 the General Assembly completely reorganized the structure of the executive branch of the state government. All independent boards and commissions were abolished and administrative functions were assigned to state departments each headed by a director who was responsible to the governor. All examining boards with a health orientation or interest were placed within the jurisdiction of the Division of Examiners in the state Department of Public Health. Also created by the reorganization act in this Division was a Board of Examiners in Medicine which took the medical licensing and regulation that was formerly administered by the Public Health Commission. A later modification of the organization of state government in 1939 resulted in a change in the name of the department to State Department of Health, and shortly thereafter the Division of Examiners was given the more descriptive name Division of Professional Regulation. By statute the administrator of this division was made the administrative officer of all of the boards coming within the division's purview including the Board of Examiners in Medicine.

Basic Science Law

The year 1940 saw the passage of the state's basic sciences law the adoption of which had been urged for several years by both the Health Department and the State Medical Society. The need for such a law was indicated by the appearance of increasing numbers of medical cultists throughout the country, especially the so-called natureopaths who with little or no training in the premedical sciences were setting up offices for the treatment of the sick. In several states these cultists succeeded in winning statutory recognition. The stated purpose of our basic sciences law was to require certification of the education and knowledge in the basic sciences underlying the practice of the healing art of all applicants for a license to practice.

It is interesting to note that since shortly after its formation in 1915 the National Board of Medical Examiners was recognized by the Rhode Island licensing agency and diplomates of that board were licensed by endorsement after an oral examination or interview, provided they possessed the qualifications required for licensure in the state. However, Rhode Island did not issue any licenses by reciprocity or endorsement to licentiates of other states until 1947, when we entered into endorsement agreements with Connecticut, Massachusetts, New Hampshire and Vermont. In 1950 a communication was sent to the licensing agency of all other states in the country to explore the possibility of establishing endorsement agreements with them. As a result of this by the end of 1950 Rhode Island completed such agreements with thirty-three other states. Within the next few years similar agreements were in effect between Rhode Island and all of the other fifty states with the exception of New York and Florida. Under these endorsement agreements the applicant must have passed a licensing examination in another state and must present evidence of meeting our requirements as an individual. He must also appear for an oral interview before the members of the Rhode Island Medical Board. The endorsement agreements stipulated that the other state would accord similar recognition on the same basis to Rhode Island licensees. This widespread recognition and acceptance of our licensees is tangible evidence of the high regard and good repute that the nation accords to Rhode Island's medical standards.

continued on next page

It is interesting to note that on several occasions during recent years applicants for licensure in Rhode Island who were diplomates of the National Board and therefore eligible for certification by endorsement elected to waive this privilege and to submit instead to our two-day written examination. Their explanation of this seemingly odd choice of the more difficult method of licensure was that in their opinion a Rhode Island medical license based on regular state board examination was more readily accepted by some other jurisdictions than the National Board. This was especially true in some instances because of the fact that we are a basic sciences state. An even more remarkable incident attesting to this occurred a few years ago when a physician, who had been practicing in this state for several years on a license obtained by endorsement of his National Board examination, asked that he be allowed to submit to our regular written test. He was advised that this could be done only if he would surrender the license he already held and waive all rights to it and then take and pass the regular state board battery of tests. This he did.

Board Responsibilities

The members of the Medical Board devote a considerable amount of time to their official duties and accept the public responsibilities that go with such service with serious consciousness of the need to strike a fair balance between individual rights with their attendant problems and the need for public order through strict enforcement of the requirements for certification. These board officials are vested with wide discretionary powers and must exercise them with mature judgment and complete objectivity. It is regrettable that at times the decisions of the board are made more difficult by the intervention of established practitioners in the community that are made on behalf of an applicant who has either failed to pass the examinations or who has been refused admission to the examination because of some lack of necessary qualification. It is realized that in most instances these petitioners who are seeking some special consideration or waiver are acting in good faith, and the board appreciates receiving all available professional opinions and evaluations of an applicant's fitness and ability. It should be known, however, that it is the board's standing policy to review with great care all borderline questions concerning qualifications or examination grades before final disposition of the matter. Whenever it can in good conscience, the board tries to resolve borderline questions in favor of the candidate. If it is necessary in order to reach a fair and valid evaluation of an inconclusive written examination, the board allows the applicant the opportunity to appear for a supplemental oral examination. This privilege is reserved for only those few real borderline situations that occur only infrequently. Obviously the board cannot grant special reviews of examinations or arrange special oral examinations for every applicant who is rejected as some members of the profession appear to feel should be done if a candidate appeals to them for intervention.

During World War II and the period immediately following those war years it was the policy of the board in its discretion to give a liberal interpretation of its rule requiring applicants for licensure to serve at least one year of rotating internship in an accredited hospital. In many instances the board accepted what it considered to be clinical training that was comparable to the experience a candidate would normally acquire during his internship. The current regulation of the board of examiners in medicine concerning internship and hospital training reads as follows: "Candidates must . . . file . . . proof of at least one year's rotating internship in a hospital approved for internship by the Council on Medical Education and Hospitals of the American Medical Association and then only if such hospitals are approved by this division at the time the internship was served. No candidate will be admitted to the examination pending the completion of his internship year. The Rhode Island Board of Examiners in Medicine in its discretion may accept as a substitute for the year of rotating internship the satisfactory completion by an applicant of the two-year program for General Practice approved by the Council on Medical Education and Hospitals of the American Medical Association. Candidates who submit satisfactory evidence to the division that they have completed at least three years of either intern or resident training or a combination of both in a specialty in a hospital accredited for training in that specialty by this division will not be required to present evidence of having completed one year of rotating internship. This exemption applies only to graduates of approved medical schools located in the United States or Canada and does not modify the rotating internship requirement for foreign graduates."

Since the World War II period there has been a great influx of foreign-trained physicians, and it has been necessary to screen their credentials and evaluate their education and fitness with the greatest of care. The board is proud of its record in the treatment and handling of the foreign diplomate. It has considered each of these applications on an individual basis, cognizant of the often tragic conditions which necessitated the physician's removal to this country and the corollary problems of readjustment and reorientation to a different set of professional standards and ethics. The success of the board in this area is demonstrated by the number of foreign-trained physicians who have successfully established practice in Rhode Island. Many of these contributed greatly to the health of our citizens by

completing several years of hospital training and practice prior to establishing their own offices. With the advent of the Educational Council for Foreign Medical Graduates in 1958 the problem of evaluation of the foreign medical graduate was greatly simplified. It is now required that all applicants who are graduates of foreign medical schools must possess a full qualifying certificate from that national screening agency before they can be considered by our board (Table 1).

The Rhode Island Board of Examiners in Medicine is truly appreciative of the co-operation that has been accorded to it by the Rhode Island Medical Society and its several component associations. It is also thankful for the understanding and confidence in it that has been manifested by the individual practitioners throughout the state and by the public.

Because we who minister to the human body and mind hold a sacred trust in our hands, we are solemnly obligated to keep medicine free from impurities and defects. Nothing but the best should be tolerated by medicine.[2]

[2]Excerpt from address by Leonard W. Larson, M.D., President of the American Medical Association. *Medicine Role in Self-discipline and Continuing Education*

TABLE 1

Portrays the comparative results achieved on medical licensing examinations by graduates of domestic medical schools and candidates who received their training at foreign medical schools. Also included for each year is the number of foreign and domestic applicants who were licensed by endorsement either on the basis of having passed the examination of the National Board of Medical Examiners or prior licensing examination in another state.

Year	Foreign Graduates		Domestic Graduates		Licensed by Endorsement	
	Passed	*Failed*	*Passed*	*Failed*	*Foreign*	*Domestic*
*1962	20	6	2	1	2	28
1961	18	9	3	0	7	22
1960	22	7	5	0	1	23
1959	25	9	5	0	0	32
1958	42	1	3	0	11	17
1957	36	1	8	0	4	29
1956	39	8	5	0	2	25
1955	35	16	8	0	3	29
1954	34	8	7	0	1	21
1953	25	4	5	0	0	31
1952	24	1	12	0	0	26
1951	7	0	5	0	0	30
1950	2	1	10	2	0	17

*First eight months.

87th CONGRESS
2d SESSION

H. R. 10

IN THE SENATE OF THE UNITED STATES

. . . but now you can build a personal pension with tax deductible dollars

The law recently passed is named the Self-Employed Individuals Retirement Act of 1962. Every doctor may use it to his advantage. It makes them employees for purposes of qualified pension plans. Allowable contributions and deductions are specified. Procedures for accumulating and distributing savings for retirement purposes are described.

Get the details today! Learn how this law applies to you. Just mail the coupon below.

EUGENE T. LOTHGREN
CRAIG D. POTTER

Pension Research
Room 410
146 Westminster Street
Providence 3, Rhode Island

I am interested in obtaining information on how I can have a Tax-Deductible Pension Plan.

(NAME).....

(ADDRESS).....

(TELEPHONE.....

(DATE OF BIRTH).....

Medicine Around the World . . .

VISITING HOSPITALS ON THE DARK CONTINENT

LAURENCE A. SENSEMAN, M.D.

The Author, *Laurence A. Senseman, M.D., of Lincoln, Rhode Island, Chief, Department of Neuropsychiatry, Pawtucket Memorial Hospital; Medical Director, Fuller Memorial Sanitarium, South Attleboro, Massachusetts.*

A TRIP to Africa is a rewarding experience during these days of rapid change in the "Dark Continent." My mission to Africa was to deliver a series of lectures on alcoholism at the medical school in the University of South Africa, Witswaterand, Johannesburg. My trip was under the auspices of the International Commission for the Prevention of Alcoholism. A two-week Institute was held at the University under the supervision of Dean Cluver of the Medical School.

My flight took me from Boston to England via BOAC and after a pleasant day and a half in London, I flew by night via Barcelona on the longest leg of the journey which was to Lagos, Nigeria. There I was met by Doctor Hershal Lamp, an American physician, connected with the Ile Ife Hospital, a Seventh-day Adventist Mission Hospital, 140 miles from the airport. This hospital serves a community of 140 to 150 thousand people and is the only hospital in that area. It has 120 beds, which does not tell the whole story; 15,000 patients were admitted in three years, and during the year 1961, 6,000 in-patients were admitted. There were approximately 1,000 deliveries, over 1,000 major operations, and 3,000 minor operations. Of interest was the fact that there were 400,000 out-patients in three years and 135,000 patient visits last year. This was accomplished with three full-time doctors and one doctor who served only six months of 1961. The ratio of doctors to population is 1:60,000 in Nigeria. There is one dentist for every two million people.

This hospital does not have a food service. In fact, the patient, when taken to the hospital, is accompanied by a member of the family or a friend. It is the duty of this person to supply the food for the patient. Often it is the mother or father and he or she will stay right in the hospital with the patient, sleeping on a mat on the floor under the bed. It is strange to walk through a hospital ward at night and see feet sticking out from underneath the bed, or two people in one bed, or a mother sleeping with the baby in the pediatric ward. To say that all beds are full all the time is an understatement, as there are usually twice as many people milling around the ward as there are beds. The situation is chaotic compared with our orderly ward service.

A look at the early morning line of patients at the out-patient clinic would discourage the average doctor. However, these mission doctors at the Ile Ife Hospital were enthusiastic and interested, working long hours without complaint. Clinical material is endless, tropical diseases fascinating.

Besides this hospital, they operate two "bush clinics" one of which I visited in Omou. This was 110 miles up into the jungle. This was a fascinating experience as there is no other medical facility in that entire area. The chief had donated the land with a maternity hospital of 10 beds, a clinic building, and a place for the dresser or nurse to live and the doctor to stay on overnight visits. This is the nucleus for a hospital in the area.

Any hospital in Africa should be evaluated only in the light of circumstances of the area which it serves. Only in this way can one have the right perspective for these institutions. By our standards, they would not measure up, but by African standards they are rated very high.

I visited briefly the University Hospital at Ibadan. This is a large 500-bed hospital, modern in every respect; in fact, it presents a tremendous contrast with the city of Ibadan which consists largely of mud brick houses with corrugated metal roofs. It is the largest African city with 750,000 natives. The University Hospital serves all of Nigeria, and during my brief stay we referred to it several interesting problem cases for diagnosis. This hospital is the medical center with a medical school for this new nation. It is interesting also to note that many of the patients are not used to beds. They take their mats with them to the hospital and sleep on the floor in preference to the beds, even in this new and modern hospital.

I then visited the Aro Hospital in Abeokuta, which is a mental institution. I was disappointed

continued on page 636

Editorials

MEDICAL COSTS AND THE DOCTOR

Operating costs of American hospitals increased by nearly one billion dollars between 1960 and 1961. Based on the annual survey of 6,923 hospitals by the American Hospital Association, the costs for 1961 were 9.4 billion dollars as compared to 8.4 billion for 1960. In each year some 67 per cent of the total amount represented payroll costs. The increase in hospital costs is reflected locally in the current round of increases in hospital per diem rates.

With approximately two thirds of all hospital costs representing wages, and with little opportunity for mechanization to replace trained people in the care of patients, automation has little to offer in hospital management, as it does in industry, toward offsetting the effect of yearly wage increases. Hospital employees in Rhode Island have not been organized by trade unions, but the competition of industry for personnel and the effect of minimum wage laws have had strong impact on hospital costs.

Another contributing factor in rising hospital costs is the increasing effect of research and education on medical practice. New drugs and more complex and costly research and diagnostic apparatus are being added to the hospital armamentarium. The latter introduce new services and require specially trained personnel. These new services, as well as educational and research activities, improve patient care, but also cost money.

As a result of escalating hospital costs there has been a progressive escape from full coverage by the various Blue Cross plans. The hospitals, properly, have not been deterred from raising rates to meet costs.

During the lifetime of the Rhode Island Medical Society Physicians Service, however, there has been no corresponding significant adjustment in fee schedules to accommodate for the physician's increase in costs. During this period his rent, labor costs, and materials have also risen. Yet the established fee schedules have not been altered significantly in over ten years. Hospital benefits, with certain semantic exceptions, such as drug charges, are on an indemnity basis, and not a service basis. In other words, the hospitals can bill the patient for increased costs when these are not covered by Blue Cross, and this has nothing to do with income limits. Physicians on the contrary cannot be expected indefinitely to provide service benefits for certain segments of the population, if their own increased business costs, and the cost of living, are not eventually recognized and taken into account.

COMPARATIVE MEDICINE

Comparative medicine as a term should stir up memories, fascination, and curiosity in the hearts and minds of most physicians. Most medical students have their first introduction to medicine in the form of comparative anatomy. In medical school, much of their physiology is in reality comparative physiology. The field of comparative medicine, however, is yet to be formed as a separate discipline. There is human medicine and there is veterinarian medicine, and there is a subspecialty of veterinarian medicine sometimes referred to as zoo medicine. It is in the concept of comparative medicine, however, that the great intellectual challenge occurs. The new Animal Centre in New York City was formally dedicated recently. The first International Symposium on Comparative Medicine was held in honor of the occasion. The similarity and, more important, species and animal differences in the reaction to infectious disease agents, neoplasia, degenerative diseases, and psychological behavior were discussed on a comparative basis. It appears that there is a field for young physicians with a strong biological research interest to enter this fruitful interdisciplinary specialty. The need and the application are limitless. The practical reward will be the broader fundamental understanding of the differences in enzyme systems, variability in reaction to stress and aging of various tissues by comparative systematic studies; indeed all experimental medicine, which is the root of medical progress, will be improved with a more fundamental understanding of medicine on a comparative basis. The pendulum has swung from

continued on next page

broad interest by the ancients and the great Renaissance natural historians to the utter narrowness of species medicine and specialization within a species on a given subject of today. A need for some individuals to possess that rare faculty of seeing the whole instead of narrow parts has returned.

There is a need for more and more ultra-generalists as well as for ultra-specialists in medical and paramedical fields. It is extremely important to produce medical men of high intellectual capacity in sufficient numbers both to meet the immediate health needs of conventional medical care, and to provide for the countless areas of expanding intellectual interest in other medical fields. A striking example of the latter is this latest of specialties, comparative medicine.

The following editorial is reprinted from THE NEW ENGLAND JOURNAL OF MEDICINE with permission of the publisher. With the opening of the 1963 Rhode Island General Assembly imminent, we feel that this analysis of the current status of chiropractic on the national scene should be of interest to our readers.

CHIROPRACTIC TRENDS

THREE RECENT superior-court judgments regarding chiropractic practice, together with petitions to state legislatures to extend the scope of chiropractic practice, indicate an increasing campaign by the chiropractor to encroach further on the field of medical practice, to rid chiropractic of its stigma as a cult and, as suggested by one research group, to survive.

Chiropractors may be licensed to practice in all states except Massachusetts and Louisiana, where the practice of chiropractic is specifically forbidden, and Mississippi and New York, where chiropractors have no legal recognition.

In the four states where chiropractic is either forbidden or not recognized, chiropractors annually seek licensing legislation. In such states as Rhode Island, Nebraska, Kentucky, New Jersey and Colorado, they frequently attempt to extend their practice beyond hand adjustments of the spine, broadening their practice to include minor surgery, obstetrics and use of drugs.

On January 31, 1962, Judge John Stuart Frazier, of the Los Angeles Superior Court, in the case of *California State Board of Medical Examiners, plaintiff, v. Harriet E. Hightower, D. C., defendant,* decided "that the practice of obstetrics by chiropractors was never intended or authorized by the Chiropractic Act, an initiative measure adopted in 1922, and that a claim of any chiropractor to so practice is without right."

In the fall of 1961 Judge Walter C. Allen, of the Los Angeles Superior Court, in the case of the *Chiropractic Research and Ethics Society, plaintiffs, v. California State Board of Medical Examiners, defendants,* ruled, in essence, that chiropractors may not prescribe drugs, practice obstetrics, possess narcotics or perform minor surgery.

On May 4, 1962, the New York Supreme Court, Appellate Division, Third Judicial Department, the Honorable William H. Coon presiding, upheld the action of the Commissioner of Public Health in banning use of X-ray equipment by chiropractors — an action that he had initiated in 1958 but postponed pending the outcome of the suit initiated by the Chiropractic Association of New York.

Although all chiropractors profess to adhere to the same theory of the cause and cure of disease as propounded by D. D. Palmer in Davenport, Iowa, in 1895, the conflict between the "straights" and the "mixers," discussed in the *Journal* on February 6, 1958, and again on September 28, 1961, persists. On one hand are the "straights," who see no reason to depart from hand adjustments of subluxations of the spine. On the other hand are the "mixers," whose departure from the D. D. Palmer line is apparent in the aforementioned suits and legislative activity.

The champion of the "mixer" school is the National Chiropractic Association, which has accredited only 8 of the extant 15 schools of chiropractic in the country and Canada. The cause of the "straights" is championed by the International Chiropractors Association, which, naturally, approves the 7 schools not approved by the National Chiropractic Association.

In an extensive survey of chiropractic in California by the Stanford Research Institute at the request of the John Randolph Haynes and Dora Haynes Foundation, published in 1960 (*Chiropractic in California*), a question regarding the apparent future outlook for chiropractic in California, on the basis of this research, was answered, in part, as follows:

> To become a part of modern medicine, chiropractic would have to compete, in essence, with the well-established medical institutions. However, chiropractors and chiropractic students are declining in number. Within the institution itself there is a conflict of philosophy and a struggle for control. Furthermore, the schools are in financial difficulty with no apparent relief in sight. These facts suggest that chiropractic does not have the strength to compete more successfully than it has in the past in a field (the healing arts) which is

generally characterized by an increasing degree of scientific approach, greater financial investment, and higher standards of practice.

The report pointed out that there "are several long-range developmental possibilities to consider," whose range includes the following:

1. The emergence of the "straights" as a specialized health field, such as is dentistry or psychiatry.
2. The emergence of the "mixers" as medical men—"chiropractic physicians and surgeons."
3. The general continued decline of chiropractic as a profession in its present form.

The report sees the first possibility as "improbable," the achievement of the second possibility as "questionable," and the third as "most realistic."

Because the "mixer" group is pushing legislation and court action it is in a relative sense more vital and appears to be winning its internecine struggle for strength and prestige, although losing by degrees its struggle for survival and public acceptance.

Discussing the definition of chiropractic in the *Journal of the NCA* for April, 1962, James E. Bunker, of Webster City, Iowa, general counsel for the National Chiropractic Association, writes, "Those who insist that chiropractic is not in any sense the practice of medicine have failed to present any substantial or persuasive reasons why this obsolete position should be maintained by the profession." Mr. Bunker suggests that the ideal method of handling the definition problems would be to avoid or abolish the use of definitive language altogether.

A distinction "on the basis of methods employed in approaching health problems has much to recommend it," Mr. Bunker writes, adding:

> You would not be limited by the dogmatic and unscientific approach of the "philosophical" practitioner and would thus be entitled to substantially greater recognition and professional status. If you were not limited as to the conditions which you could properly care for, you could include in the scope of your practice all conditions for which you could provide a measure of relief or cure. Coupling with this the right to treat any area of the body, you would then be able to care for traumatic injuries such as strains and sprains of ankles, wrists, arms and knees, and also respiratory conditions which make up the major portion of acute illnesses.

Additional legislative petitions and court actions to alter the various state chiropractic licensing laws are anticipated.

COUNCIL OF THE NEW ENGLAND STATE MEDICAL SOCIETIES

THE RECENT highly successful and well-planned New England Postgraduate Assembly held in Boston, November 5-8 focuses attention upon the important, but unheralded activities of the Council. The Assembly, formerly a rather wayward offspring fathered by the Massachusetts Medical Society, has more recently acquired in the Council a steady and permanent sponsor. The Boston meeting, arranged in co-operation with The New England Chapters of the American Academy of General Practice, provided postgraduate credits to members of the Academy who attended.

The Council has other functions which should be better known to members of the component societies. The most important recent accomplishment of the organization was the setting up of the Beacon Investing Corporation, an open end mutual fund conducted solely for the physicians of the area. The administrator of the fund is the solid National Shawmut Bank of Boston and investment counsel is Standard and Poor. The economy with which the fund is operated and the philosophy of sound investment which it has followed in its brief history should make this a highly attractive instrument for investment by the members. An incredible amount of work by the Council preceded the launching of this program.

Another recent activity has been the sponsorship of a group Professional Overhead Expense Insurance plan for members. On the basis of the prospectus, this seems to be an inexpensive and worthwhile plan to supplement other group policies presently available to physicians. There is in addition continuing study of other group types of insurance, such as professional liability. The membership of some 14,000 gives the Council an advantage in bargaining with the underwriting companies.

Presently the Council is investigating ways of making available to members whatever advantages there may be in the newly passed Federal Self-Employed Individuals Tax Retirement Act of 1962, commonly known as H.R. 10. The full implications of the legislation are still under study by analysts. It is anticipated that changes will be made in its provisions. There is every probability, however, that the Beacon Investing Company will find a way to participate in the trust provisions of the law.

Among its several activities, the Council hopes to establish a New England Hospitality Room and co-ordination among New England delegates at A.M.A. meetings. This function will help to mobilize and integrate the full organizational resources of the New England group of societies, both as to available delegate strength and society membership

continued on next page

in A.M.A. Councils. The interests of New England doctors are more often alike than disparate.

A few additional comments about the New England Postgraduate Assembly may be in order. Probably as a hold-over from its former Massachusetts sponsorship, the Assembly continues to have a strongly Massachusetts orientation. Meetings have always been held in Boston and even this year the roster of speakers was predominantly from Boston. The Council should not lose sight of the fact that Boston is the hub of the universe only to a Bostonian. The speakers should in the future be recruited increasingly from areas outside of Massachusetts, even outside of New England. The location of the meetings should be moved periodically to such centers as New Haven and Hartford, perhaps even to Providence. Attendance from Rhode Island has always been small. Some greater feeling of participation by Rhode Island physicians would likely increase interest locally. There are also, we might point out, medical centers in northern New England which have been largely neglected in the past as sources of talent. We urge that a desire for a greater role in planning and participation in this event among members to the south of Dedham and north of the Merrimack be not dismissed as mere restless grumbling among the proletariat.

IT COULD HAPPEN HERE

The National Health Service was established in Great Britain approximately 14 years ago. Since its inception, every poll that has been taken shows that the majority of people there are in favor of their socialized medical program where all medical care is "free." So, if popularity is an effective test, it has been a political success — actually a bonanza. However, an onimous crack and rumble has broken the happy illusion. *Although the doctor's bills have vanished, so have the doctors, and at an almost incredible rate.* (italics ours) The fact that there is a dwindling supply of doctors in Great Britain is now unquestioned. Whereas it has not disturbed the legislators unduly, it has disturbed their physicians who have recognized that the bright and shining political promises have cheated the people who happily suppose they are counting their blessings.

In the early years of the National Health Service, British students entered the medical schools in their accustomed numbers. After his years of study, sacrifice, and toil, the young British doctor's "reward" was that he was not actually a physician or a professional man, but a government tool or functionary, and was paid like a clerk. He had lost the status that the doctor and physician in England once possessed. He was told where he must practice, and because the "free care" patients crowded his waiting room he could not give the patient before him the care, thought, and time that, as a good physician, he would like to do so that one of his original motives had been thwarted completely. . . .

Increasing numbers of them have emigrated to the United States, Canada, Australia, New Zealand, and other areas where a doctor is still a physician and not a government clerk. Meanwhile, doctors from India and Pakistan and other developing nations are coming to Britain and are finding ready positions made vacant by the mass medical migration.

A recent issue of the BRITISH MEDICAL JOURNAL contained interesting and enlightening information. It was therein noted that between 1950 and 1959, 27 per cent of all doctors added to the New Zealand register were graduates of British medical schools, and nearly all were British citizens. The average annual exodus of British doctors to Australia between 1957 and 1961 was 225. As in the case of New Zealand, a quarter of all new doctors to the medical register of Australia were from British schools. In the 5 year period between 1956 and 1960, an annual average of 150 graduates of British medical schools obtained licenses to practice permanently in the United States. During an 8 year period between 1953 and 1960, an annual average of 203 British medical graduates entered Canada as immigrants, whereas essentially no Canadian doctors have settled in Britain in the past 15 years.

In the 5 year period between 1956 and 1960, 1,060 British doctors have registered in Australia, 749 in the United States, 1,071 in Canada, 184 in New Zealand, and 466 in South Africa and Rhodesia. The average of over 600 doctors registering annually in these countries alone is equivalent to a third of the annual output of the medical schools of Great Britain and Ireland. Taking the North American continent as a whole, Great Britain has exported 311 doctors annually during the years 1953 to 1960, inclusive — a number equal to the output of 3 medical schools.

English physicians have found the National Health Service to be unattractive to them economically, professionally, and idealistically. There has been a steady decline in medical students. The younger generation of the British medical profession is already severely depleted. Observations made in hospitals throughout England indicate that most have few British doctors working in them under the age of 40, and many have none. . . .

. . . Extracted from editorial by KENNETH L. PICKRELL, titled *The Aftermath of Socialized Medicine in Great Britain*, from SURGERY, GYNECOLOGY & OBSTETRICS, Nov., 1962.

Patronize Journal Advertisers



For peptic ulcer gastric hyperacidity and gastritis...

In year-long study on peptic-ulcer patients

New Creamalin® Antacid Tablets

*"...faster in onset of action...and for a longer period"**

"Clinical studies in 85 patients with duodenal ulcer ...confirmed the superiority of the new preparation [new Creamalin] over standard aluminum hydroxide preparations, in that prompt relief was achieved and maintained throughout the period of observation."*

Patients were followed for about one year.

New Creamalin promotes ulcer healing, permits less frequent feedings because it is so long-acting. Heartburn and epigastric distress were "...easily and adequately controlled...."* New Creamalin has the therapeutic advantage of a liquid antacid with the convenience of a palatable tablet. *It does not cause constipation.*

Each new Creamalin tablet contains 320 mg. of specially processed highly reactive dried aluminum gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. Minute particles offer a vastly increased surface area.

Dosage: Gastric hyperacidity—from 2 to 4 tablets as needed. Peptic ulcer or gastritis—from 2 to 4 tablets every two to four hours. *How Supplied:* Bottles of 50, 100, 200 and 1000.

Now also available—New Creamalin Improved Formula Liquid. Pleasant mint flavor—creamy pink color. Stabilized reactive aluminum and magnesium hydroxide gel (1 teaspoon equals 1 tablet). Bottles of 8 and 16 fl. oz.

Creamalin, trademark reg. U.S. Pat. Off.

*Schwartz, I. R.:
Current Therap. Res. 3:29, Feb., 1961.

Winthrop LABORATORIES New York 18, N. Y.

VISITING HOSPITALS ON THE DARK CONTINENT

continued from page 630

that I missed seeing T. A. Lambo, the superintendent, who is the only board certified psychiatrist in Nigeria. He apparently passed us en route to the University Hospital. Aro is an 80-bed psychiatric facility with a large out-patient service. These out-patients are really patients cared for at government expense. They are placed in homes of the people in the area, who are paid by the government for this care. Those engaged in this service are given instructions in the care of mental patients. The patients are thus cared for in their own environment and seem to do very well and at less expense. These patients visit the hospital for shock treatment and supervision of their medication. Much out-patient shock treatment is done in Aro Hospital, we were told. This hospital was the site of the recent Pan-African Psychiatric Association meeting. It is a modern facility, using all the presently accepted therapeutic procedures. It was neat and clean and would be considered a first rate psychiatric facility in any country.

I was next taken to Tantoro by Doctor Von-Severus, an Austrian female physician. This is where they keep the criminally insane patients. It was quite a contrast to the Aro Hospital. The buildings were merely cinder block buildings with corrugated metal roofs and with little or nothing as far as furnishings were concerned. The food was served from a central kitchen which contained little more than a large central stove with large kettles placed on top for cooking. The food was served in bowls without eating utensils. The patients ate with their fingers. This institution was a grim reminder of the past as far as care and treatment are concerned.

My next flight was to Johannesburg via Brazzaville in the French Congo. During my week's stay in that beautiful city, I visited Toro Hospital, a 90 bed Provincial Psychiatric Hospital. I was shown around this institution by Doctor Vorster, a young psychiatrist from South Africa. This institution seemed like any private institution. Patients are admitted on a voluntary commitment paper. It is operating at 100 per cent occupancy, and there is a waiting list. There were many activities going on simultaneously. I was particularly interested in the puppets which the patients made themselves out of papier maché, painted and then dressed attractively. They had regular puppet shows in which the patients could act out their own feelings and emotions.

I was also interested in a nursery for employees' children. The day or night nurses could go on duty and leave their children in the nursery under the care of a well-trained employee. Several children, five and six years of age, were seen who had been "raised" in the nursery over a period of years. Many activities were arranged for the children. I thought that if such a facility were made available to us, it might solve some of the shortage of qualified nurses here. They also had day care and night care for patients in this open hospital. An active treatment program was everywhere in evidence in this fine psychiatric facility.

An unusual privilege made possible by Major Fleming during my stay in Johannesburg was a visit to a gold mine. These large mining companies supply complete medical care. All gold mines are served either by their own hospital or by a central hospital serving several mines. The 300-bed hospital I visited was well equipped, staffed by full-time medical officers and well-trained nurses. This hospital served 12,000 native employees. When I inquired as to why there were so many hospital beds, I was told that every accident victim was hospitalized regardless of how minor or severe the injury. Injuries of hands and feet were all hospitalized no matter how slight the injury, the explanation being that any injury could rapidly become severe if not properly cared for by experienced hospital personnel. Natives are notorious for their neglect of personal injury. No chances were taken with possible infection resulting in more and even permanent damage for which the company would be responsible. Rigid safety rules are followed and safety films are shown to all employees and safety rules are vigorously enforced.

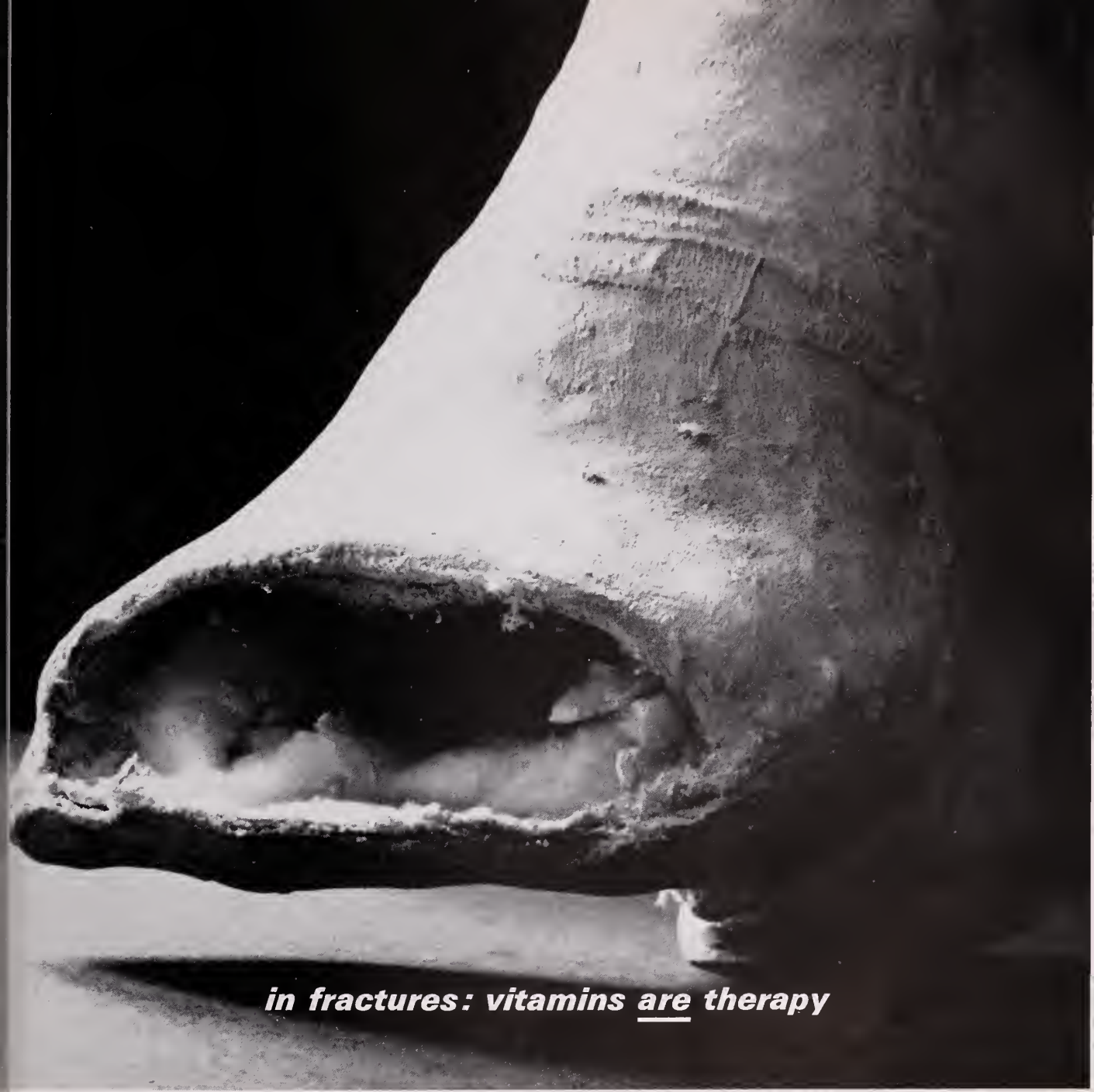
I also visited the Helen House which is a 300-bed geriatric facility, founded by Jan Christian Smuts. This is a very fine institution for the care of senior citizens and is operated on a private basis, supported by local charities and philanthropic minded citizens in Johannesburg.

I next visited a Mission Hospital in Basutoland, at Maluti, about 220 miles south of Johannesburg. Much of this area looks like our southwest and is a very primitive area. The long drive was rather rewarding, as we went through some very interesting country and had a good glimpse of how the Bantu natives live in South Africa.

The Maluti Hospital is a 130-bed institution and considered the best in this British Protectorate. Doctor Staples, the medical director, is an eye specialist trained in eye surgery as well as general medicine. Doctor Clifford, a brother-in-law, is also a F.R.C.S. These two busy physicians took care of 530 deliveries, 1,200 operations in 1961, plus 12,000 to 15,000 out-patients a year. During my brief visit here I saw cases of acute tuberculosis, osteomyelitis, and meningitis. There is a nurses' course at this Mission Hospital and 30 nurses are in training. Seven graduated the past year. The building is modern and comfortable even by our standards.

Ethiopia is a wonderful, exciting, and interesting

continued on page 638



Few factors are more fundamental to tissue and bone healing than nutrition. Therapeutic allowances of B and C vitamins are important for rapid replenishment of vitamin reserves which may be depleted by the stress of fractures. Metabolic support with STRESSCAPS is a useful adjunct to an uneventful recovery. Supplied in decorative "reminder" jars of 30 and 100.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.

STRESSCAPS®

Stress Formula Vitamins Lederle

VISITING HOSPITALS ON THE DARK CONTINENT

continued from page 636

country, historically and ethnologically, geographically and medically. It was a privilege to visit this ancient country now awakening in this twentieth century and alive with activity, but very needy in many respects.

The Emmanual Hospital in Addis Ababa is not exactly a tourist attraction. This is the only mental hospital in Ethiopia. It is a 240-bed institution, and the only psychiatrist in Ethiopia, Doctor Kapotos, is in charge. He is a Greek physician and very much overworked. When I met the doctor in his small office, there were six other people crowded about his desk: his body guard (he keeps the patients from attacking the doctor), dresser (not an R.N.), stenographer, interpreter, a pharmacist, and the patient! The doctor asked why I should want to see his hospital, as if suspicious of my motives in doing so. I assured him it was to see how he was carrying on psychiatry in this distant land.

I was conducted through all six cinder block buildings with 40 patients in each. There was little if any of the comforts of life, just beds, 20 in a row on each side. There was one lavatory and one shower in each building. The linen was far from clean, but the doctor seemed proud to tell me there were no bed bugs, the reason for this being that the "linen" is sprayed frequently with DDT. The sheets were filthy. I asked about alcoholics, and they stated they had not had any since they had been there. This was probably due to the economic situation in the country. The population was made up mostly of schizophrenics, manic depressives, and other psychotic patients. The women psychiatric patients, many nude, were quite noisy and disturbed.

One building which particularly disturbed me was that for the criminally insane. I heard the clinking of chains. It was the first time I had experienced this ancient sound, even as it must have been 100 or more years ago. Patients had chains about their ankles and were chained to the bed; others had chains about their wrists. When I asked about this, the doctor shrugged his shoulders and said, "What can you do with patients who run away?" He admitted some had been confined like this 7-10 years. They told me they gave 80-90 electroconvulsive treatments a week. They were using one tranquilizer, chlorpromazine, but little if any sedation. Most patients received just custodial care, little more.

Doctor Kapotos asked if I had any suggestions to offer. I suggested securing, if possible, more professional help, such as a psychiatrist, psychiatric social workers, and psychiatric nurses. He laughed and said there were none available in Ethiopia, and furthermore he had a budget of only $36,000 a year which was reluctantly supplied by frugal minded politicians. This small budget was for salaries, food, repairs, and supplies. The average employee gets $10.00 to $20.00 per month! The doctor also has a good-sized out-patient clinic to maintain alone. His last remark was: "Send someone over to help us!"

I came away from that hospital with a depressed feeling and much sympathy for that courageous physician who deserves some sort of recognition for his heroic contribution to the mentally ill of Ethiopia.

The Empress Zauditu Hospital in Addis Ababa is operated by Seventh-day Adventists with two United States doctors and one Danish doctor. Doctor Robert Rigsby, a young, enthusiastic physician, is in charge of this 87-bed hospital which is soon to be enlarged. I was told that the new building would include an Imperial Suite, as many of the Emperor's family have been patients in the hospital, and a Crown Prince was born there.

An interesting but frightening experience was told to me during my visit at the hospital. During the recent attempt to overthrow His Majesty Haile Salassi, the loyal Palace guard and the Army were slugging it out in front of the Royal Palace in Addis Ababa, and the hospital was located in this cross fire. For a week they carried on their hospital routine with patients in the hallways for protection and sleeping under mattresses at night. Doctor Rigsby has a souvenir bullet on his key chain which came through the roof of his home, struck the fireplace above his head, and dropped harmlessly at his feet.

Working at this high altitude of 8,000 feet is rather exhausting to one unaccustomed to it. There are many out-patients seen daily at this hospital, and more medical help is needed to do adequate work, as the clinical material is unlimited. I visited the Ros Clinc, operated by the Empress Zauditu Hospital Staff, in another part of the city of Addis Ababa. It was an interesting experience in tropical diseases, which are so prevalent in Africa.

Ethiopia is primitive by our standards. The city of Addis Ababa is teeming with people, most of whom seem poorly fed and housed. Transportation for the average Ethiopian is by foot or horse-drawn cart. Only in the larger cities can cars and trucks be seen in goodly numbers. Roads are mostly rough gravel outside the cities. Buildings are either very good or poor; but Addis Ababa is changing, and the modern can be seen next to the ancient.

Everywhere I visited in Africa there was a genuine interest and respect for Americans. Many natives I spoke with expressed a desire to visit America. One government official I spoke with at the Empress Zauditu Hospital in Addis Ababa told me, with considerable pride, that he had been to the United States five times on government busi-

concluded on page 640



Coca-Cola, too, is compatible with a well balanced diet. As a pure, wholesome drink, it provides a bit of quick energy ... brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE-MARK ®



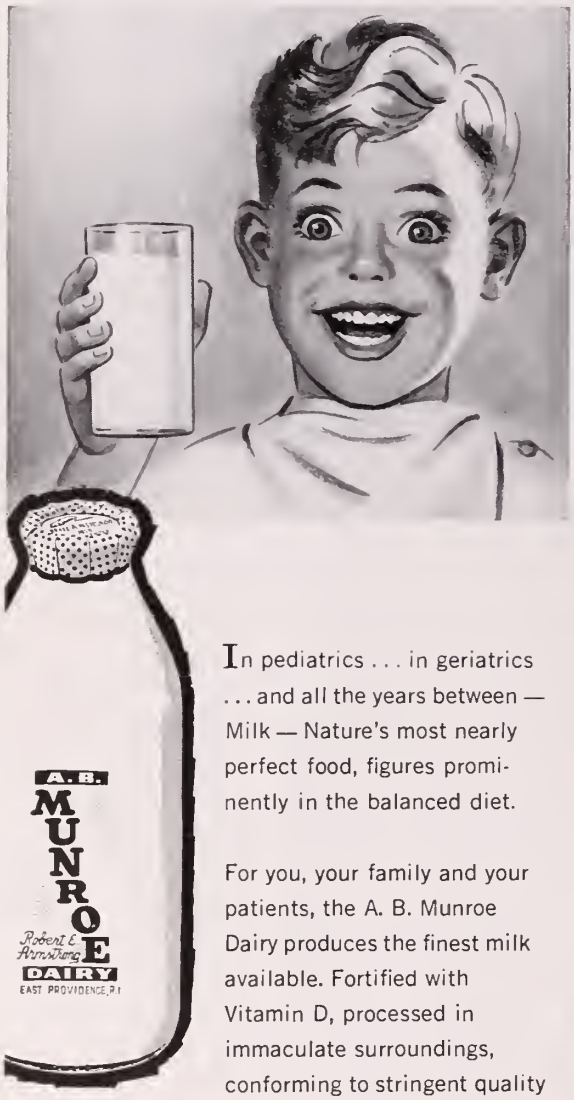
Wherever you go forget your telephone calls. We'll take them for you, day or night.

MEDICAL BUREAU

of the

Providence Medical Association

"your very good health"



In pediatrics . . . in geriatrics . . . and all the years between — Milk — Nature's most nearly perfect food, figures prominently in the balanced diet.

For you, your family and your patients, the A. B. Munroe Dairy produces the finest milk available. Fortified with Vitamin D, processed in immaculate surroundings, conforming to stringent quality requirements, A. B. Munroe milk is the ultimate in purity and safety.

RHODE ISLAND QUALITY MILK ASSOCIATION MEMBER

A. B. MUNROE DAIRY, INC.
151 Brow Street, East Providence, Rhode Island

Call GE 8-4450
for Home Delivery

VISITING HOSPITALS ON THE DARK CONTINENT

concluded from page 638

ness. He seemed impressed with our American standard of living.

The practice of medicine, too, is improving in Ethiopia. I was given Vol. I, No. 1 of the ETHIOPIAN MEDICAL JOURNAL, which has just been published, their society just reaching maturity.

One month spent on this, the second largest continent, is hardly enough to permit one to draw any conclusions, except that it offers the physician a tremendous challenge. That the "Dark Continent" is awakening is an understatement. It is alive, vital, and progressive. The new countries are struggling for their survival, identity, and independence. They look to us for understanding, assistance, and medical aid. Many physicians are needed if only for a short period of service in the native hospitals. The A.M.A. has been encouraging such an effort on the part of the individual doctor. Such an opportunity to be a good will ambassador is indeed a wonderful experience and privilege. It is a great source of encouragement to those who are dedicating their lives to these underdeveloped peoples who need so much medical attention, but have little or nothing.

HOW SOCIAL ARE THE FOUNDATIONS?

Both inside and outside the foundation world, the feeling is growing that, in contrast with their great and dramatic days earlier in the century, the foundations have somehow lost their way. The leading philanthropies then were under the direct guidance of powerful and imaginative donors and were suffused with the reformist mood of the time. Those were the days of the Flexner report, which revolutionized medical schools; of the Carnegie public library program and of the founding of the Rockefeller Institute.

But today, although the number of foundations is growing rapidly, their impact on the nation is less marked. They have become more organized, professionalized and impersonal. They are no longer unique, nor even predominant, in their role as financiers of research. And in the past decade a blight of grayness and mediocrity has begun to spread over their grants. . . .

— Extracted from *How Social are the Foundations* by WALDEMAR A. NIELSEN, formerly of the Ford Foundation and now president of the African-American Institute, in the New York TIMES Magazine, Oct. 21, 1962.

Hospital Income Vs. Outgo

It cost patients $33.91 per day, on the average, to stay in the nation's general hospitals last year — and it cost the hospitals $36.04 per day to keep and care for them.

The difference of $2.13 per patient day was made up through contributions and grants.

According to the American Hospital Association, patients paid a total of $4,314,000,000 to general hospitals in 1961. To all hospitals they paid $6,407,000,000. Fifty-eight per cent of the latter amount, or $3,687,000,000, was paid by health insurance benefits.

DISTRICT MEDICAL SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

A JOINT DINNER meeting of the Newport Naval Medical and Dental Officers and the Newport County Medical Society was held at the Commissioned Officers Mess at the Newport Naval Base on September 19, 1962 with Captain Joseph L. Yon, M.C., U.S.N., commanding officer of the U.S. Naval Hospital, presiding. Invited guests attending included Capt. Dawson A. Mills, M.C., U.S.N., executive officer of the Naval Hospital; Capt. Oliver Finnigan, commanding officer of the Naval Station; John E. Farrell, SC.D., executive secretary of the Rhode Island Medical Society; Arthur Hardy, M.D., president of the Rhode Island Medical Society, and Donald Fletcher, M.D., president of the Newport County Medical Society.

Following the dinner, Frank J. LePreau, M.D., civilian consultant at the Naval Hospital, gave an illustrated talk on his experiences as a medical missionary in Kenya, East Africa and in Haiti. Doctor LePreau emphasized the importance of voluntary medical missionary work in promoting international good-will and pointed out that the natives are eager and willing to learn, particularly in East Africa. He paid high tribute to the medical missionaries laboring in both areas and especially to the Mellon family for their philanthropic work in Haiti.

RICHARD R. KNOWLES, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, October 1, 1962. The meeting was called to order by the president, Doctor J. Merrill Gibson, Sr., at 8:30 P.M.

Minutes of the April Meeting

Doctor Gibson noted that the minutes of the April meeting had been published in the RHODE ISLAND MEDICAL JOURNAL and therefore they would not be read unless there was a request for such a reading. There was no request and therefore he stated the minutes would be considered accepted as published.

Report of the Secretary

Doctor William A. Reid, secretary, reported the following special actions taken by the Executive Committee:

The application for associate membership of Doctor Khalil Shekarchi, of Warwick, a member of the Kent County Medical Society, has been approved.

Doctor Edward S. Cameron, of Providence, was named to be the Association's representative on the board of the newly formed Air Pollution Control League.

The appointment of Doctor Joseph Lambiase to fill the unexpired term of Doctor J. Merrill Gibson, Jr., on the House of Delegates of the Rhode Island Medical Society, was made by the president and approved by the Committee.

The report of the Entertainment Committee was received and approved.

Action: It was moved that the report of the Executive Committee be approved. The motion was seconded and passed.

Applications for Membership

The secretary reported that the Executive Committee had approved the applications for active membership in the Association of the following: George K. Boyd, M.D.; Farag Y. Chamuel, M.D.; Carl F. DeLuca, M.D.; Alfred E. Fireman, M.D.; David R. Hallmann, M.D.; Charles L. Hill, M.D.; John G. Pierik, M.D.; Martin J. Shorr, M.D., and Jose Vergara, M.D.

The motion was made, seconded and passed that the applicants approved be elected to active membership.

Announcements by the President

Doctor Gibson noted that since the April meeting the Association had lost one member by death, Doctor Benjamin Sharp. He requested a minute of silent prayer for Doctor Sharp.

Doctor Gibson called to the attention of the mem-

continued on next page

DERMATOLOGIST TO ADDRESS PAWTUCKET PHYSICIANS

The President of the Pawtucket Medical Association has announced that the guest speaker at the January 17, 1963 meeting will be Dr. Herbert Mescon, Chairman and Professor of Dermatology, Boston University School of Medicine.

His talk will concern itself with skin problems of interest to the General Practitioner.

The meeting will take place at the Lindsey Tavern, Smithfield Avenue, Pawtucket, at 8:15 p.m., and all physicians interested will be welcomed.

bers the Pediatric Symposium at Roger Williams Hospital on October 10, the Gerber Oration to be given at Miriam Hospital on October 24, and the Kenney Clinic Day at Pawtucket Memorial Hospital on Wednesday, October 31.

Guest Speakers

Doctor Gibson introduced Mr. Devine of the Cushman Air Ambulance Service who had a display exhibited in the rear of the auditorium. Mr. Devine briefly reported on the facilities available to physicians for air transportation of their patients.

Doctor Gibson introduced Mr. E. A. Palmer, general manager of the Greater Providence Chamber of Commerce, who addressed the members on the subject of *The Doctor's Role in the Chamber of Commerce*. He explained with illustrations the activities of the Greater Providence Chamber of Commerce.

The president introduced Doctor Gordon M. Meade, clinical director of the Miners Memorial Hospital Association, who reviewed *The Medical Care Program of the Miners Memorial Hospitals*. Doctor Meade's paper will be published in full in a subsequent issue of the RHODE ISLAND MEDICAL JOURNAL.

The meeting adjourned at 10:40 P.M.

Attendance was 42.

Collation was served.

EQUIPMENT FOR SALE

Medical-urological equipment, including X-ray outfit. All in perfect condition. Call: WI 2-3122.

Dr. V. J. Oddo

322 Broadway Providence, R. I.

FOR SALE

One National Twin Type Pistol Electric Cautery in excellent condition. Priced very reasonable.

Call: PA 6-1912

SURGEON GENERAL URGES ORAL POLIO VACCINATIONS

Doctor Luther L. Terry, surgeon general of the Public Health Service, said early in October that the Special Advisory Committee on Oral Polio Vaccine has reiterated its recommendation that Type III oral polio vaccinations be continued for preschool and school age children but not for adults at this time.

The recommendation was reached at a meeting of the Committee on September 15. The Committee, which met at the Service's National Institutes of Health, recommended that local communities proceed with planned mass vaccination campaigns using Types I and II of the oral vaccine for all members of the population and Type III for children.

The sequence of feedings, the Committee pointed out, is of minor significance as long as the interval of at least six weeks is maintained.

In endorsing this recommendation Doctor Terry said: "The recommendation that Type III be confined to children has raised the question of spread from vaccinated children to adults especially family members. The evidence does not indicate a hazard to adults exposed in this way."

The Committee considered two new cases reported as poliomyelitis to the Service from the state of Nebraska, both in adults. Three additional suspect cases, all children, are under investigation in Nebraska. While diagnostic information is incomplete, these cases present some features not typical of polio, and the committee could not reach a conclusion at this time as to a possible association with Type III vaccine. Additional diagnostic laboratory information will be gathered to assess the possibility of some other neurological disease that may simulate polio.

The surgeon general said that the date of the next Committee meeting had not been set. "The meetings, of which this is the fourth, will continue," he said, "as long as there is a need for them."

Doctor Terry said that one of the Committee's continuing purposes is to provide guidance for a positive program of polio immunization for the nation.

ORAL POLIO

SUNDAY . . . MARCH 1

SPECIAL COUGH FORMULA
for Children

Pediacof®

SOOTHING DECONGESTANT AND EXPECTORANT

Each teaspoon (5 ml.) contains:

Codeine phosphate	5.0 mg.
Neo-Synephrine® hydrochloride (brand of phenylephrine hydrochloride)	2.5 mg.
Chlorpheniramine maleate	0.75 mg.
Potassium iodide	75.0 mg.



Bright red, pleasant tasting, raspberry flavored syrup

Dosage:

Children from 6 months to 1 year, 1/4 teaspoon; 1 to 3 years, 1/2 to 1 teaspoon; 3 to 6 years, 1 to 2 teaspoons; 6 to 12 years, 2 teaspoons. Every four to six hours as needed.

How Supplied:
Bottles of 16 fl. oz.

Available on prescription only.

Exempt Narcotic

Winthrop
LABORATORIES
New York 18, N Y

BOOK REVIEWS

CIBA FOUNDATION SYMPOSIUM. The Exocrine Pancreas. Normal and Abnormal Functions. Editors for the Ciba Foundation: A. V. S. de Reuck and Margaret P. Cameron. Little, Brown & Co., Boston. $11.50

This is medical literature at its best. Interest in the pancreas previously has been centered on the endocrine function because of its role in diabetes. Exocrine function interest has been heretofore impossible because of impure secretin and cholecystokinin. Practical physiological interest in pancreatic exocrine function therefore has suffered. Lately, availability of secretin and cholecystokinin for diagnostic procedures has reawakened interest in the pancreas by clinicians. The failure to recover pancreatic juice in the small intestine by intubation except after the use of secretin has prevented the cytologic study of pancreatic juice for carcinoma of the pancreas in its earliest stages. There is some reason to believe that this may eventually be clinically available but at this writing is still available only for research purposes. Cholecystokinin as shown in this book has great possibilities in conjunction with X-ray examination of the gall bladder. All the aforegoing interest in the pancreas from a clinical viewpoint occupies a small but balanced part of this CIBA collection.

The book is extremely well balanced and consists of approximately four hundred pages. It might well be titled, THE COMPLETE EXOCRINE PANCREAS. Anatomy, and superb ultra-anatomy with electron microscopic pictures begins the first section. The histochemistry, the physiology of secretion, biochemistry of metabolic action of the pancreatic juices, the nervous and hormonal control, normal and abnormal digestive function as related to the pancreas and the two outstanding diseases of the pancreas, namely — hereditary pancreatitis and cystic disease of the pancreas, are concisely and adequately covered in good balance.

The authors of the individual papers are all internationally famous and were gathered together for only one reason — their interest in the exocrine pancreas. It is small wonder then that this little volume is so attractive. It is extremely authoritative, profusely illustrated, and conceived in perfect balance and presentation. This gives to the total work a symmetry that is pleasing, as are all works of art which firstly contain good form and lastly good material.

ROBERT V. LEWIS, M.D.

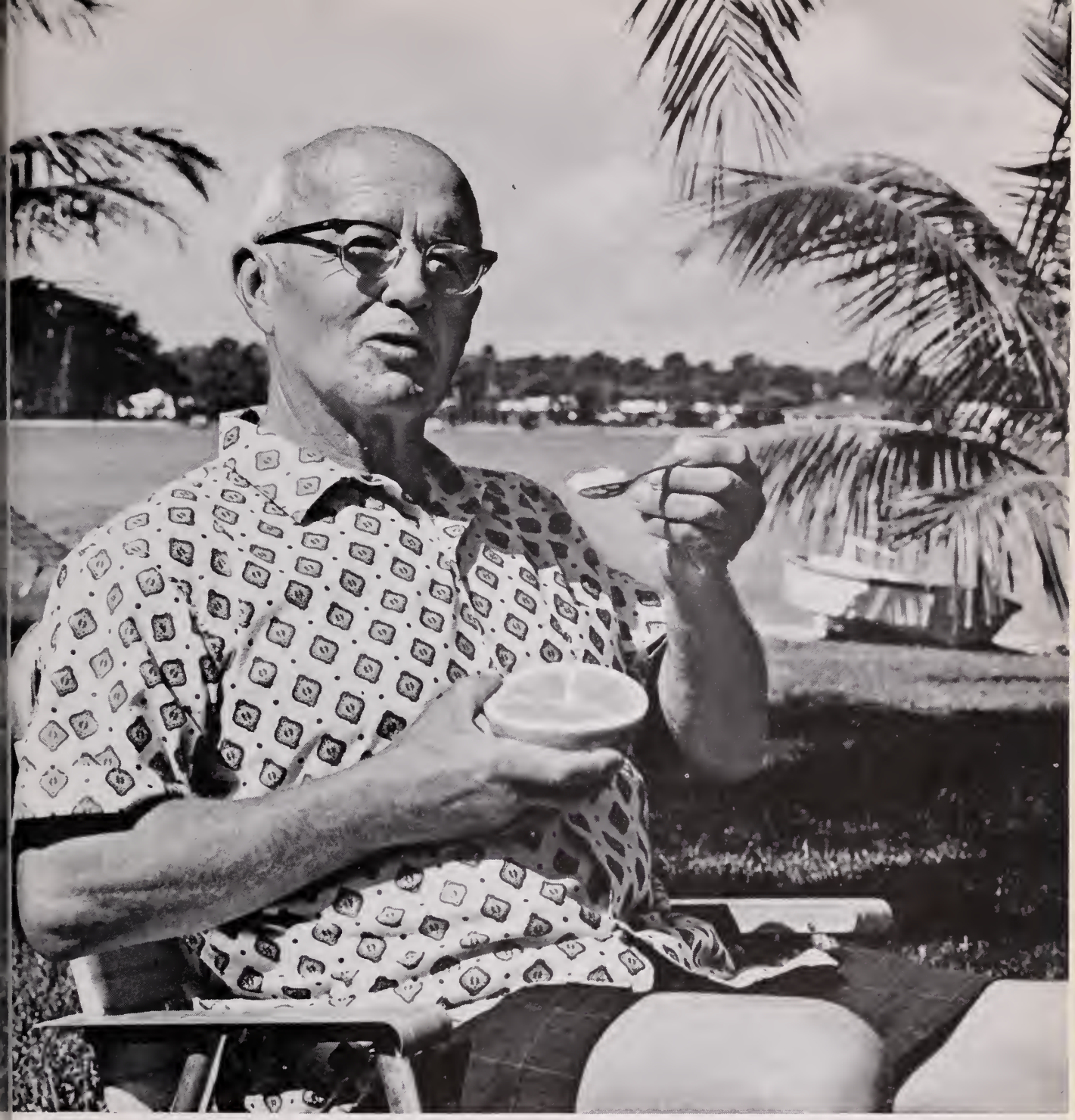
Novak's *GYNECOLOGIC AND OBSTETRIC PATHOLOGY* with Clinical and Endocrine Relations by Edmund R. Novak, M.D., and J. Donald Woodruff, M.D. Fifth Edition. W. B. Saunders Co., Phil., 1962. $16.00

This edition, the fifth, represents the first edition of this classic monograph on obstetrical and gynecological pathology to which the original author, Emil Novak, did not contribute. Since his death his son, Doctor Edmund Novak, and the new author Doctor Donald Woodruff have combined to continue in this excellent publication. As stated in the *Preface*, these authors are supervising the work of the Laboratory of Gynecologic Pathology at Johns Hopkins.

This work contains 35 chapters, approximately 713 pages with 761 illustrations of which 31 are in color plates. The text covers in anatomical fashion the diseases of the vulva, vagina, cervix, endometrium, uterus, fallopian tubes, paraovarian and uterine ligaments, and the embryology and histology of the ovaries; classification of ovarian tumors including chapters on various types of ovarian tumors. The section on obstetrical pathology includes discussions of ectopic pregnancy, fertilization, implantation and placentation, including abortion, hydatidiform mole, and chorionepithelioma. These three chapters have been written by Doctor Robert E. L. Nesbitt, now professor of obstetrics and gynecology at the New York State University at Syracuse. The final chapter is edited by Doctor John K. Frost, an expert on the subject of gynecologic and obstetric cytopathology. Almost 100 pages of the book are devoted to this most important phase of gynecological diagnosis.

As was true of Doctor Emil Novak's editions, this book emphasizes the clinical and endocrine relations of the practice of obstetrics and gynecology. The book has been a standard work for practically all candidates of the American Board of Obstetrics and Gynecology, and will continue to be so. The clarity of style and the accuracy of the clinical information make it a useful and necessary handbook for residents and interns in training in the field of obstetrics and gynecology. The general

continued on page 646



The good life–just what the doctor ordered

Sea and sun are both in his doctor's orders — so is that grapefruit he's eating with such gusto. Citrus fruit is a wonderful way for this patient or any patient to get his daily quota of vitamin C . . . to enjoy something good to eat, tasty and satisfying but not rich.

Not all patients are so lucky as to have retired to Florida, where they can just reach out to pick citrus fruit off their own orange and grapefruit trees. But any patient anywhere can get the same benefits of the natural vitamin C in Florida oranges, grapefruit, and tangerines . . . thanks to modern methods of processing fresh fruit. Whether it is frozen, canned, or in cartons, 98% of the vitamin C content of the fruit is preserved.

Grapefruit and other citrus fruits filled with vitamin C are valuable in the nutrition of every age group. Among the teen-agers, vitamin C is one of the two nutrients most often low in the diet. Infants, too, need generous amounts of vitamin C; and they will take it readily when it comes to them in the form of delicious orange juice.

When your patient chooses *Florida* citrus, he can be sure of getting fruit filled with natural goodness and of just the right sweetness. Florida citrus is unexcelled because a State commission watches over the entire Florida citrus crop to see that it meets the world's highest standards for fresh, frozen, canned or cartoned citrus fruits or juices

© Florida Citrus Commission, Lakeland, Florida

BOOK REVIEWS

continued from page 644

pathologist will find this a handy reference for a major portion of his surgical pathology. Although there may be occasional areas of disagreement in interpretation of some of the morphologic changes, this book represents a tremendous collection of experience and wisdom applied to the pathological entities of obstetrics and gynecology. Since both of the new authors are relatively young men, we shall look forward to numerous additions of this classic in future years.

GEORGE W. ANDERSON, M.D.

PHYSICAL DIAGNOSIS by Ralph H. Major, M.D., Mahlon H. Delp, M.D. Sixth Edition. W. B. Saunders Company, Phil., 1962. $7.50

This is the sixth edition of Major's textbook of PHYSICAL DIAGNOSIS, which, in my opinion, has been a classic in its field since first it appeared in 1937. Since that time it has been an important source of information and instruction for many physicians and medical students, and with each succeeding edition it has taken on a polish and perfection which cause the reader to forget that it is a text and to consider it more as a fascinating exposition of the art and science of the physical examination. The association of physical diagnosis with the great men in medicine from the time of Hippocrates is stressed, and this helps make the factual information more interesting and pertinent.

History taking and recording is the concern of the first chapter. This is followed by a chapter on pain and its relationship to physical findings. Next is the study of general inspection of the patient, and then follow chapters on the examination of the head and neck, chest, lungs, heart and cardiovascular system, abdomen, genitalia, extremities, and finally on the examination of the nervous system. The text is profusely illustrated by diagrams and photographs — 527 to be exact.

The prose style is direct, clear, and smoothly flowing. The result is not only a textbook; it is interesting material for bedside reading. One cannot say that about many textbooks.

JOHN A. DILLON, M.D.

MAN AND DOLPHIN by John C. Lilly, M.D. Doubleday & Co., Inc., Garden City, N.Y., 1961. $4.95

A dolphin's brain is as big and potentially as good as man's. Only the dolphin, the related whales, and the elephant in the entire animal kingdom possess a brain that is in any way comparable in potential intellectual capacity to man.

John C. Lilly, M.D. skipped his internship at the University of Pennsylvania in 1942 and continued his fundamental interest in biophysics and neurophysiology in the Johnson Foundation. His fundamental training in science at the California Institute of Technology from which he graduated in 1938 well prepared him technically and intellectually for the magnificent work reported in this book.

Lilly was looking for a brain outside of man, possessing a cerebral cortex which was capable of intellect and language function as opposed to simple instinct and intelligence. Chance reading that a whale had been washed up on the Maine coast began his interest in whales' and dolphins' brains. Thus began a life study upon which to concentrate and focus his tremendous knowledge and resources, for which his peculiar education had equipped him.

This is pleasant reading of a nontechnical nature, written almost as if by a naturalist. His unusual capacity not only for natural observation but also for scientific observation characterizes his style. He recounts in a fascinating historical way the development of his interest. He philosophizes and stimulates by the breadth of his intellectual curiosity applied to the matter of inter-species communication, by new perspectives in viewing nature, and by extrapolation to almost all of creation.

In one hundred pages of appendices, a storehouse of knowledge concerning the anatomy and physiology of Tursiops Truncatus (dolphin) is listed. A résumé of cerebral cortical function on a comparative basis, anatomically and physiologically, is appended, following which there is a short sketch of the paleontology of both man and dolphin.

This is a unique book without a peer. It is in the tradition of the great naturalists, Darwin, Humboldt, and Goethe, but with technical twentieth century scientific knowledge brought to bear on natural philosophy, by a person uniquely endowed for his task. I believe this book is a classic for all time.

ROBERT V. LEWIS, M.D.

HANDBOOK OF PSYCHIATRIC TREATMENT IN MEDICAL PRACTICE by Nathan S. Kline, M.D., and Heinz Lehmann, M.D. W. B. Saunders Co., Phil., 1962. $3.50

It appears that this book has been written with a very definite purpose, namely to increase the use of chemotherapy among a widening circle of practitioners.

The authors are right in saying that a large number of patients with mild psychogenic disorders (such as psychophysiologic stress reactions and mild anxiety reactions) can be successfully treated by the general practitioner. One of many assets of the G.P. is his awareness of the family background interaction. Yet, by including depressions and psychotic reactions and by delaying their referral by

continued on page 648

WILLIAM H. Harris
New England's Largest Exclusive Furrier
400 Westminster Street

anything darling... as long as it's a harris mink



Our Mink collection of lovely scarfs, stoles, jackets and coats is priced from $99. to $6950.

ATTENTION MEN!

Your selection held and gift wrapped for Christmas. Any purchase cheerfully exchanged within one week after Christmas.

Trained gift counsellors will assist you.

Charge or Budget Terms Available

LIFE INSURANCE or DEATH INSURANCE?

SOME Medical men need DEATH Insurance ONLY.

Others need accumulating, guaranteed dollar values to meet their LIVING needs in the future — DEPRESSION — EMERGENCY — RETIREMENT, etc.

In any event, our new "CHEAPER-THAN-TERM" DEATH INSURANCE is the first step in the right direction!

Don't make any important changes in your Life Insurance or Estate plans without investigating "CHEAPER-THAN-TERM"!

For further information about this sensational new development in DEATH INSURANCE, write or phone:

ROLAND A. DEROSIER
54 Custom House Street
Providence 3, Rhode Island
TE 1-4833

KIDS ARE GOOD FOR WARWICK CLUB GINGER ALE



It sings in the glass



Fuller Memorial Sanitarium

Located on Rt. 1

South Attleboro, Massachusetts

A modern non-profit hospital for the care and treatment of nervous and emotional disorders as well as long term geriatric problems.

Physical, neurological, psychiatric and psychological examinations.

Modern recognized psychiatric therapies.

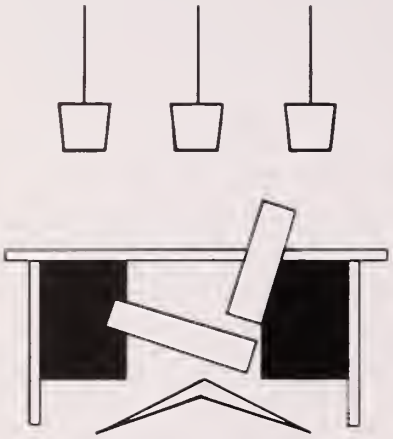
A pleasant homelike atmosphere in a beautiful and conveniently located institution.

L. A. Senseman, M.D., F.A.P.A., Medical Director
Edwin Dunlop, M.D. Michael G. Touloumtzis, M.A.
Oliver S. Lindberg, M.D. William H. Dunn, M.S.W.
W. H. Lesovsky, M.D., Ph.D.

Referred patients are seen daily (except Saturdays) 9-12 A.M., and by appointment.
R. I. Blue Cross Benefits Tel. Southgate 1-8500

Special Rates for Long-Term Care

Attractive & Functional Offices
by BENÉ & CO., INC.



Designers & Suppliers of Offices
150 Dorrance Street • Providence 3, R. I. • GAspee 1-5228

AIR AMBULANCE SERVICE

To any part of the country — day or night. Multi-engine equipment, air line rated pilots. Fully equipped amblance, stimulant tray, oxygen therapy etc. Registered nurse on all trips. We can transport stretcher cases in and out of the smallest airports.

No increase in rates over ground transportation

CUSHMAN'S
AIR AMBULANCE SERVICE

47 NISBET ST., PROVIDENCE, RHODE ISLAND
Call DE 1-4840

BOOK REVIEWS

concluded from page 646

several months, the authors tread on dangerous ground. Some of the conditions are difficult to evaluate even to a man trained in the field. From this point of view the book may give a false sense of security to the reader.

The paragraphs containing the list of psychopharmacological drugs in the U.S.A., Great Britain and Canada is helpful. So is the description of management of the side effects.

CATHERINE ZOURABOFF, M.D.

PERIPHERAL VASCULAR DISEASES by Edgar V. Allen, M.D.; Nelson W. Barker, M.D.; Edgar A. Hines, Jr., M.D., and others. Third Edition. W. B. Saunders Co., Phil., 1962. $18.00

This is the third edition of a classic monograph on peripheral vascular disease (first edition, 1946; second, 1955) and a fitting memorial to the late George Elgie Brown, M.D., pioneer investigator and designer of the work.

Primary vascular disease and intravascular thromboembolic phenomena are assuming ever greater roles in contemporary morbidity and mortality. Reading of, and reference to, this book is desirable by students, and medical and surgical physicians.

Inclusion of cerebrovascular phenomena for the first time in this third edition is a welcome addition.

If a criticism can be made of so excellent a book, it will be that the diseases of the lymph vessels and their relationship to other vascular diseases is treated somewhat abruptly.

While the book is broadly based on statistical data and the literature (with most excellent bibliographies chapter by chapter), the authors have preserved a primary interest in the clinic, in the patient with the disease; in the simple, the obvious (all too often forgotten), and the practical. In this connection a pocket-sized synopsis edition, if feasible, would be welcome.

Reading this book, your reviewer became starkly aware of the limits of his knowledge of vascular diseases. I submit that PERIPHERAL VASCULAR DISEASES can show even far better informed physicians additional implications of vascular disease in their fields of specialized interest.

EDMOND B. SINCLAIR, M.D.

SUNDAY . . . MARCH 3, 1963

ORAL POLIO SUNDAY

SCANNING THE MEDICAL LITERATURE

VASCULAR BIRTHMARKS OF INFANTS. Francesco Ronchese, M.D. Skin 1:12, 1962.

Infantile vascular birthmarks, of the type commonly seen in dermatologic and pediatric practice, are benign vascular tumors, which usually occur in patients up to 6 months of age, at which time they ordinarily reach their maximum size.

Methods of dealing with these disorders, listed alphabetically, are: cosmetics and tattoo; electrocoagulation and electrolysis; no therapy (in expectancy of spontaneous involution); radiation; refrigeration (carbon dioxide snow); sclerosing solution injections; surgery.

The selection of therapy depends on the type and size of the tumor, on its location, the child's sex, and the parents' co-operation.

NAIL DEFECT AND OCCUPATIONAL TRAUMA. Francesco Ronchese, M.D. Arch. Dermat. 85:404, 1962.

A worker engaged in the removal of 2,800 chicken feedbags per hour every working day with 3 fingers of one hand developed a severe onychosis with separation and loss of the nails of the same 3 fingers. The nails were not normal. They were splitting in thin layers (onychoschizia lamellina). The congenital anomaly contributed considerably to the development of the occupational onychosis.

BURROWING HAIR (PILI CUNICULATI). Francesco Ronchese, M.D. Arch. Dermat. 85:540, 1962.

A case is reported of a penetration of a human hair under the skin; penetration most likely occurred in the ordinary process of drying, rubbing, or massaging the skin.

Horizontal penetration of hair into the skin is rare and peculiar. For this condition the term embedded hair has been used. Burrowing hair (pili cuniculati), from the way the acarus of scabies burrows into the skin to deposit its eggs, is considered more appropriate.

LUNG CANCER IN NARGHILE SMOKERS

A study among different ethnic groups in Israel, a report by J. Rakower and F. Fatal in the BRITISH JOURNAL OF CANCER for March, 1962, showed that the lung cancer mortality rate for the immigrants from Europe was 8 times as high as that for the immigrants from Yemen despite the fact that the Yemenites were heavier smokers than the Europeans. Seventy-eight per cent of the Yemenite smokers were narghile smokers, while 98 per cent of the European smokers were cigarette smokers. Only 7 per cent of the narghile group but 88 per cent of the cigarette-smoking group were inhalers. The fine cigarette tobacco was found to yield more tar than the coarse tobacco (tombac) used in narghile smoking. The efficiency of the narghile water filter was not appreciably higher than that of a cigarette filter tip. The findings of this study are compatible with the assumption that mainly differences in inhaling account for the fact that the lung cancer death rate in the narghile smoking population is significantly less than among the cigarette-smoking group.

"HOERR'S LAW"

The surgeon is a man of action. By temperament and by training he prefers to serve the sick by operating on them, and he inwardly commiserates with a patient so unfortunate as to have a disease not suited to surgical treatment. Young surgeons, busy mastering the technicalities of the art, are particularly alert to seize every legitimate opportunity to practice technical maneuvers, the more complicated the better.

In an effort to remind my young colleagues, as well as myself, that our goal as physicians is the betterment of the lot of the patient, I have formulated a ten word statement that I have modestly named *Hoerr's Law*.

It is difficult to make the asymptomatic patient feel better....

— Extracted from an editorial by STANLEY O. HOERR, M.D., Surgeon of the Cleveland Clinic, in the AMERICAN JOURNAL OF SURGERY, April, 1962.

THROUGH THE MICROSCOPE

concluded from page 615

Breakthrough on World-Wide Malaria Eradication Possible

A single injection of a new drug given volunteers nearly a year ago is continuing to protect them from malaria induced by heavily infected mosquitoes which have been allowed to bite them at monthly intervals. Other volunteers not given the drug invariably come down with malaria after being bitten by these mosquitoes.

Results of clinical trials of the long-lasting antimalarial, which thus far has been protective nearly ten times longer than conventional suppressives, were reported recently to members of the American Society of Tropical Medicine and Hygiene meeting at Atlanta, Georgia, by Doctor G. Robert Coatney of the National Institutes of Health, research bureau of the Public Health Service. He reported remarkable initial success with the new experimental drug, designated as CI501.

Developed by scientists at Parke, Davis & Company, Ann Arbor, Michigan, CI501 is an experimental drug, not yet available for general use. It was supplied by the company to Doctor Coatney and his associates, Doctors Peter G. Contacos, Harvey A. Elder and Mr. John W. Kilpatrick, for clinical testing with volunteer patients. Parke, Davis & Company investigators and scientists at Christ Hospital Institute of Medical Research, Cincinnati, Ohio, also reported to the meeting on laboratory and animal work with the new antimalarial.

If the promise of initial trials in volunteers is borne out under actual field conditions, the CI501 compound should greatly increase the chances of success in world-wide malaria eradication efforts. The United States plays a major role in the program to eliminate this disease, which afflicts 200 million people and kills 2 million each year.

Leukemia Society Forms Rhode Island Chapter

The Leukemia Society, Inc., with national headquarters in New York City, has announced the formation of a Rhode Island Chapter under the present direction of Mr. Kenneth Boehm of 102 Whitehall street in Providence.

The Leukemia Society is a voluntary association, with chapters throughout the United States, dedicated to the conquest of leukemia through medical research, patient services and public education. It is the only national voluntary health agency concentrating all of its efforts on the fight against leukemia.

The major portion of funds raised by the Society are allocated to its medical research program. This program is based on the principle that all medically sound avenues of approach to a cure or a control for leukemia should be encouraged on a world-wide basis, and on a belief that an increasing number of scientific investigators will speed the day when the tragedy of leukemia will be solved.

Administered by a group of highly-qualified medical specialists, the Society provides support for both the individual investigator and for specific research projects.

The Society's program of aid to leukemia patients and their families is carried out by its volunteer community chapters that provide counseling, guidance and aid.

Life Expectancy Maximum Has Leveled Off

Although in this part of the world we can now expect to live about 25 years longer than in 1900, the increase in life expectancy leveled off about eight years ago, Doctor R. G. Bell, medical director of the Bell Clinic in Toronto, stated at the annual meeting of the Association of Life Insurance Medical Directors of America.

One class of chronic disability that continues to increase rather than decrease, and to grow in a variety of forms, Doctor Bell said, are the "tragedies of abundance"— the disabilities resulting from "too much"— too much food, too much tobacco, too much alcohol and "too much of a bewildering variety of drugs that depress or stimulate the human nervous system."

Doctor Bell likened addiction to "a twin-motored" abnormal force which in the case of heroin gets under way so quickly and so completely dominates all activities that it can be thought of as "jet propelled." Food and alcohol addiction usually develops much more slowly and insidiously, more like a bulldozer than a jet.

"Treatment can eventually turn off the 'twin motors' of adaptation, but the motors themselves remain capable of being restarted after years of disuse," Doctor Bell said. "Any initially rewarding activity that has become habitual can be quickly revived in this way after years of non-activity, and the old associations, attitudes and emotional reactions revived with it."

E. P. ANTHONY, INC.
Druggists
WILBUR E. JOHNSTON, Phar. D.
RAYMOND E. JOHNSTON, B.S.
178 ANGELL STREET
PROVIDENCE, R. I.
GAspee 1-2512
Pharmacy License #225

Pennsylvania Osteopathy Report Approved
(As reported in Philadelphia Medicine)

Members of the Pennsylvania Medical Society's House of Delegates, at the annual session in Atlantic City, October 10-13, voted to break down the wall that has separated doctors of medicine and doctors of osteopathy for the past 90 years and invited fully-licensed osteopaths to take steps to become medical doctors.

Two days later, the Pennsylvania Osteopathic Association's House of Delegates, meeting in Hershey, praised the PMS action and voted to continue discussions on the proposal to merge with the Society, an action which may subject them to ouster from the American Osteopathic Association.

Pennsylvania's medical doctors became the second group in the nation to take this historic action. California's doctors took the same step six years ago and all but a handful of osteopaths there have merged with the medical doctors.

The special report approved by members of the PMS House of Delegates: 1. Make it ethical for the first time for doctors of medicine and doctors of osteopathy to freely engage in consultations "significant to the welfare of patients." 2. Allows osteopathic physicians to attend graduate educational programs conducted by the PMS and other medical organizations in Pennsylvania. 3. Sets up a procedure whereby qualified osteopaths may become a part of the Pennsylvania Medical Society.

The last step has many ramifications and depends on the Philadelphia College of Osteopathy and the Pennsylvania Osteopathic Association for its development. It could eventually result in the Philadelphia College of Osteopathy becoming a medical college, in the Philadelphia College awarding the degree of doctor of medicine to current students and to osteopaths in the state who meet the qualifications, in osteopaths who accept the doctor of medicine degree becoming members of the Pennsylvania Medical Society. As a final step, the report proposed co-operating in establishing a single board of medical education and licensure to replace the separate boards in the state, a step that would require action by the legislature.

CLASSIC HEMOPHILIA AND CHRISTMAS DISEASE

Diseases due to defects in blood coagulation have been classified as (1) those due to a deficiency of factors required for thromboplastic formation; (2) for conversion of prothrombin to thrombin and (3) those due to a deficiency of fibrinogen. Disorders in the first group, due to a deficiency of factors required for thromboplastic formation, are regarded broadly as the hemophilias. Until recently the term hemophilia was applied to a single disorder, that due to a deficiency of the antihemophilic globulin (AHG). The discovery of the other two thromboplastic precursors, thromboplastin component (PTC, Christmas factor) and thromboplastin antecedent (PTA), resulted in the realization that hemophilia was indeed not a single entity but a group of entities with similar symptomatology. The disorder due to deficiency of antihemophilic globulin (AHG) is regarded as classic hemophilia or hemophilia A. The condition resulting from a deficiency of plasma thromboplastic component (PTC or Christmas factor) has been called Christmas disease or hemophilia B, and that due to a deficiency of plasma thromboplastic antecedent (PTA) is referred to as hemophilia C. All three conditions occur as hereditary abnormalities and show a bleeding tendency from childhood. Classic hemophilia and Christmas disease are inherited as sex-linked recessives, are confined almost exclusively to males and are transmitted by carrier females. In contrast, PTA deficiency (hemophilia C) is transmitted as a dominant with no sex-linkage and affects both males and females. Classic hemophilia and Christmas disease are clinically practically indistinguishable. A recent study appears to show that the gene for PTA deficiency is an incompletely recessive or "intermediate" gene which produces major PTA deficiency in the homozygote and minor PTA deficiency in the heterozygote.

. . . from *Patterns of Bone Change in Classic Hemophilia and Christmas Disease*, by JOHN E. MOSELEY, M.D., JOURNAL OF THE MOUNT SINAI HOSPITAL, New York, Jan.-Feb., 1962.

Patronize Journal Advertisers

J. E. BRENNAN & COMPANY
Leo C. Clark, Jr., B.S., Reg. Pharm.
Apothecaries
Two Convenient Locations
5 North Union Street Pawtucket, R. I.
140 Central Avenue Seekonk, Mass.
7 Registered Pharmacists
Pharmacy License #226

IN THE EDITOR'S MAILBOX

To the Editor:

With the retirement of our medical officer who has served with us for many years, this office is searching for a well-qualified physician to fill this position. We would like to recruit a doctor who has had a number of years of general practice and who is well regarded in the medical profession. Good speaking and writing abilities are important qualifications for this position. Desirable, but by no means essential, would be a knowledge of the physical demands of various professions, trades, and occupations. This last type of knowledge could be acquired after appointment.

One of the principal duties of the position would be to pass on the medical qualifications of applicants for positions in the federal government and to give instructions and guidance to other federal medical officers who do this work for their own agencies. Another principal duty would be to review medical certificates of federal employees who apply for disability retirement to determine whether they are medically disqualified for useful work in their positions. A third duty would be to establish medical qualification standards for various positions in the federal service. The Civil Service Commission is deeply interested in placement of the handicapped and we would expect our medical officer to help locate positions in the federal service suitable for handicapped people, to advise them as to positions for which they might be qualified, and to work with federal agencies in getting them placed in suitable positions.

The entrance salary of this position will be $13,695 and eight period salary increments are provided for a maximum of $17,095.

Our position normally involves regular office hours from 8:30 to 5:00, five days a week. It would require a certain amount of travel to visit medical officers at federal agencies and occasional trips to Washington. We have an excellent retirement system which would pay a minimum of 7½% of average salary after five years of service, about 26% of average salary after fifteen years of service, and an additional 2% of average salary for each year of service beyond 15. There are also liberal survivorship annuities as well as life insurance, health insurance, and annual and sick leave benefits.

I am enclosing a small supply of applications, SF-57 and CSC-2398, which I would appreciate your furnishing to any well-qualified physician you may know who might be interested in our position. These should be submitted to Mr. Robert A. Joyce, our administrative officer, at the address shown on our letterhead. We will then arrange to interview those whom we feel would be well adapted to the work.

I will be grateful for any help you can give us in filling this important position in our organization.

Sincerely yours,

RICHARD J. HEALEY, *Regional Director*

If all medical research were halted for five years, future generations would certainly suffer. New medical advances would be delayed. But if those billions of dollars that would be saved were applied to improving the standard of medical care, and if these funds became available to administer important but costly methods of diagnosis and treatment, it is not unlikely that more lives would be saved and more physical and mental help would be rendered to our population than would be lost by the five years' research that was neglected. . . .

. . . Extracted from an editorial by Doctor Samuel A. Levine titled *Speculations Upon the Temporary Cessation of Research* in the HARVARD MEDICAL ALUMNI BULLETIN issue of Fall, 1962.

DO YOU KNOW?

- That a little more than half the U.S. population has some form of eye trouble, according to the American Medical Association.
- That 40 per cent of all Americans wear glasses, 8 million sets of contact lens have been sold, and almost one million persons are blind.
- That nothing, including wearing glasses, eating carrots, or eye exercises, can cure nearsightedness, although glasses will improve vision.

Curran & Burton, Inc.

INDUSTRIAL
AND WHOLESALE

COAL **OIL**

17 CUSTOM HOUSE STREET
PROVIDENCE, R. I.
DExter 1-3315

The extra-firm mattress selected by over 9,000 doctors for their own use

Assures both preventive and corrective support—used in more American homes than any other special design

Sealy Posturepedic is the first mattress designed in cooperation with leading orthopedic surgeons to promote normal, healthful sleep among *all* persons.

As a "corrective device" it serves those chronically afflicted with lower back syndromes. As a preventive measure Sealy Posturepedic brings deep spring buoyancy without bedboard hardness to everyone—plus the concomitant blessings of unexcelled comfort and extra-firm support.

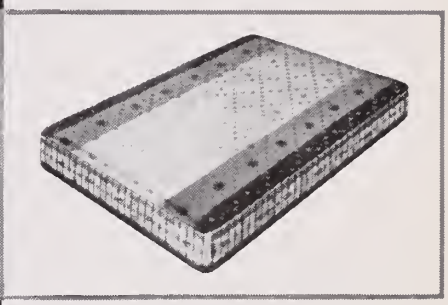
These are basic to good health. The therapeutic value of restful sleep is especially recognized during these tense and anxious days. Sealy Posturepedic eminently meets this need by supplying level spine support for proper relaxation of the limbs and human musculatory system.

Over 9,000 doctors of medicine have tried and bought the Sealy Posturepedic mattress and matching foundation for their own use. We believe your investigation will firmly convince you of its distinctive benefits, and, we would hope, merit your valued recommendation.

Sealy POSTUREPEDIC® BRAND

NO MORNING BACKACHE
from a too-soft mattress





PROFESSIONAL DISCOUNT OF $39.00

So that you may judge the quality of the Sealy Posturepedic for yourself, we offer a special Professional Discount on this mattress and foundation when purchased for your personal use. *Limit—one full or two twin size sets.*

SEALY MATTRESS COMPANY • Oakville, Conn.

Enclosed is my check and letterhead. Please ship the Sealy Posturepedic Set(s) indicated below:

1 Full Size ☐ **1 Twin Size** ☐ **2 Twin Size** ☐

	RETAIL		PROFESSIONAL
Posturepedic Mattress	each $79.50	(add state tax)	$60.00
Posturepedic Foundation	each $79.50	(add state tax)	$60.00

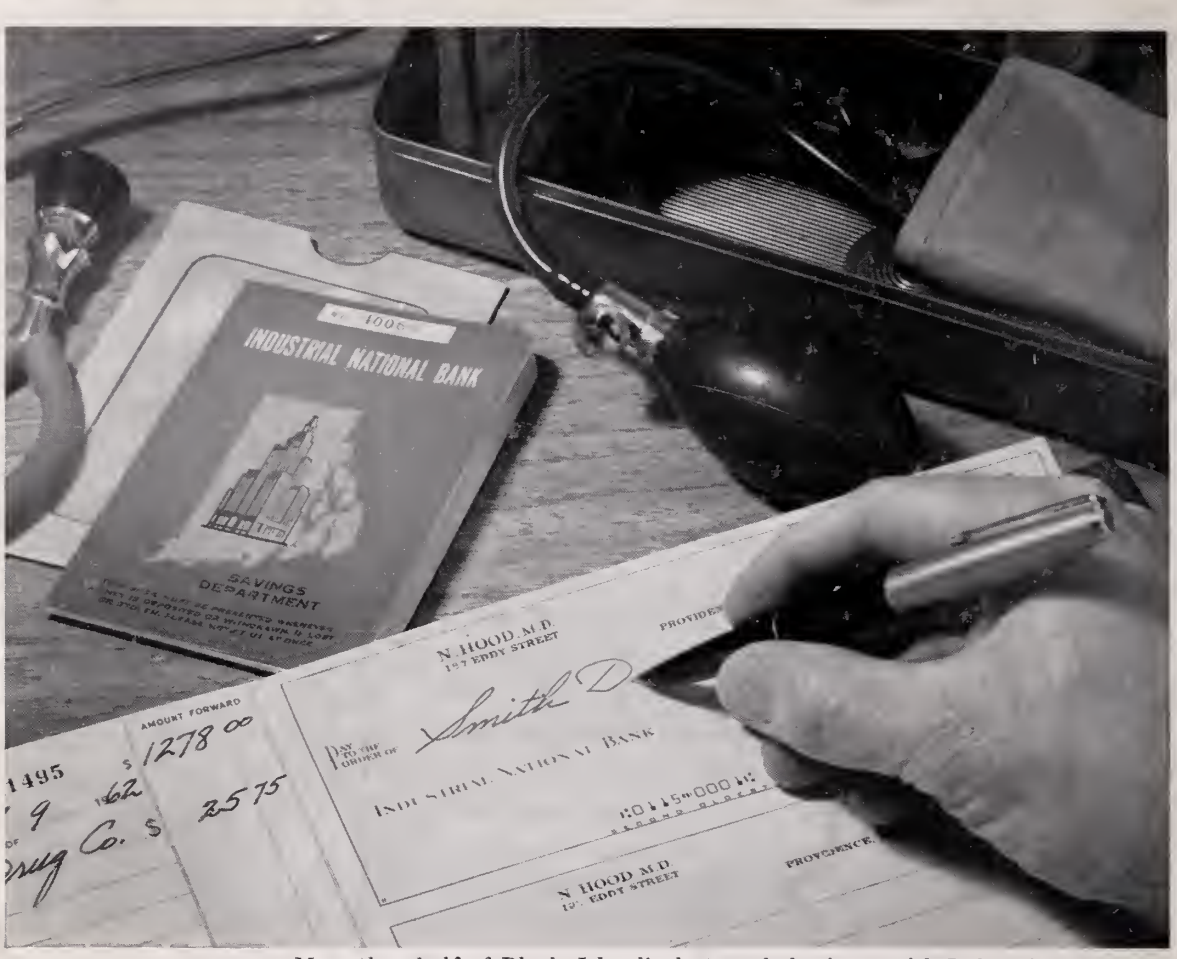
NAME_____

RESIDENCE_____

CITY_____ ZONE____ STATE_____

(This is a saving of $39.00 per set over the regular $159.00 retail price for mattress and matching foundation)

©Sealy, Inc., 1958



More than half of Rhode Island's doctors do business with Industrial National

How Industrial National Bank serves the medical profession

Industrial National offers medical people complete banking services through 45 statewide offices.

Many doctors — and nurses — make a habit of *regular* savings at Industrial National. Many have an Industrial National checking account, too. It's the safe, convenient way to handle your financial affairs.

New Budget Trust, other helpful services

The new Budget Trust is still another Industrial National service for the medical profession. It's an ideal way to build your estate . . . or help save for your retirement, children's education, or some other long-range goal.

You'll find many more of Industrial National's services helpful. Like low-cost, insured personal loans. Real estate mortgages. Safe deposit facilities.

Industrial National is convenient to your home or office. Save time, save steps. Bank at Industrial National.

INDUSTRIAL
NATIONAL BANK OF
RHODE ISLAND

46 Neighborhood Offices
Serving Rhode Island

Member Federal Reserve System
Member Federal Deposit Insurance Corporation

The New York Academy of Medicine

DUE IN TWO WEEKS UNLESS RENEWED
NOT RENEWABLE AFTER 6 WEEKS

DATE BORROWED	BORROWER